DOCUMENT RESUME

ED 259 261 CG 018 362

TITLE Suicide and Suicide Prevention. A Briefing by the Subcommittee on Human Services of the Select Committee on Aging. House of Representatives, Ninety-Eighth Congress, Second Session (November 1, 1984, San Francisco, CA).

INSTITUTION Congress of the U.S., Washington, D.C. House Select Committee on Aging.

REPORT NO House-Comm-Pub-98-497

PUB DATE 85

NOTE 62p.; Portions of the document contain small print.

PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.

DESCRIPTORS *Adolescents; Adults; Blacks; Crisis Intervention; Hearings; *Prevention; Research Needs; School Role; *Suicide

IDENTIFIERS California; Congress 98th

ABSTRACT

This document presents the transcripts of a Congressional hearing called to bring attention to the growing problem of suicide. The opening statement of Representative Tom Lantos is presented. Prepared statements of 16 witnesses are provided, including psychotherapists from the Houston International Hospital; a mother and a father of teenage suicide victims; representatives from several suicide prevention centers in California; the executive officer, American Association of Suicidology; a student at the University of California; a representative of the California State Department of Education; a representative of a member of Congress from California; the director of the Cindy Smallwood Foundation, Program on Quasi-Morticide, California; the director of pupil personnel and guidance, Oakland California Public Schools; the head of the Suicide Research Unit, National Institute of Mental Health; and a diplomate in clinical psychology from the Menninger Foundation. Topics covered include the prevalence of suicide among teens, the need for public awareness, establishment of a national centralized computer bank on suicide, prevention of adolescent and adult suicide, and suicide in the black community. (KGB)

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[COMMITTEE PRINT]

SUICIDE AND SUICIDE PREVENTION

A BRIEFING

BY THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

U.S. DEPARTMENT OF EDUCATION
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NOVEMBER 1, 1984, SAN FRANCISCO, CA

Comm. Pub. No. 98–497

Printed for the use of the Select Committee on Aging

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SUICIDE AND SUICIDE PREVENTION

THURSDAY, NOVEMBER 1, 1984

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HUMAN SERVICES,
San Francisco, CA.

The subcommittee met, pursuant to notice, at 3:06 p.m., in the ceremonial courtroom, 19th floor, Federal Building, 450 Golden Gate Avenue, San Francisco, CA, Hon. Tom Lantos (acting chairman of the subcommittee) presiding.

Members present: Representative Lantos of California.

OPENING STATEMENT OF REPRESENTATIVE TOM LANTOS

Mr. LANTOS. These hearings on suicide, of the Subcommittee on Human Services of the House Select Committee on Aging, will come to order.

The purpose of today's hearing of the subcommittee is to bring attention to the growing problem of suicide in our Nation. This tragic and unnecessary loss of lives has reached unprecedented proportions. Yet, efforts to reduce the suicide rate or to develop effective prevention programs have been largely neglected.

I requested this hearing to review what we know about suicide and to receive recommendations for Federal action. It is ironic that the role of the Federal Government in providing national guidance for research and prevention has diminished, while the problem has increased.

I want to thank the witnesses in advance for taking time to prepare their testimony and for being here today to speak in person.

I especially wish to commend Charlotte Ross, director of the San Mateo County Suicide Prevention and Crisis Center, for her untiring efforts in this field. She has contributed to public awareness both locally and nationally by working diligently on both fronts. Her involvement as technical adviser for the television film "Silence of the Heart", which was shown this week, was a major contribution to the parents and youth of America.

We in San Mateo County are proud of the Suicide Prevention and Crisis Center, which is viewed as a national model. There are many other crisis centers throughout the Bay area, the State of California, and throughout the Nation, which do an outstanding job but need encouragement.

At the outset I also wish to express my special gratitude to my legislative staff director, Dr. Edna Mitchell, who has done the bulk of the work in preparation both for this hearing and for legislation I introduced on the subject.

In June of this year I introduced legislation, H.R. 5931, calling for a National Commission for the Study of Suicide. The purpose of this Commission will be to coordinate and synthesize the data on suicide which are now scattered among different Federal agencies. We must clearly understand what is happening to whom and why.

This Commission of experts will then be able to advise Congress on public policy initiatives. If Federal funding is to be allocated for this problem, as I believe it must be, those most familiar with the complex facts must set out priorities.

The problem of this magnitude must be viewed as a national emergency. It is absolutely shocking that 30,000 Americans die each year from taking their own lives out of despair, depression, and hopelessness. The ripple effect from these individual tragedies bringing grief, guilt, and lifelong sadness to the friends and relatives of victims, and the loss cannot be calculated in monetary terms.

A deeply disturbing phenomenon has emerged recently as waves of suicides have occurred in certain communities as the result of one adolescent's death. In Plano, and Clear Lake, TX, and in Westchester County, NY, such clusters of sequential suicides have been reported.

The first death may or may not have been prevented; but surely additional suicides might have been prevented, if we had known how and if we had the local resources to help the peer group with its own adolescent reaction to the suicide of a friend.

Concern with adolescent suicide should not be allowed to obscure the fact that by far the greatest proportion of suicides are among the elderly. More than 40 percent of the suicides involve persons over 55 years of age. We are also concerned about the hidden and unspoken problem of despair among the elderly, leading them to take their own lives.

Many elderly people feel that their lives are over. Often they are sick and in pain. They routinely feel lonely and abandoned by their families, and they face dwindling financial resources. Our society must see that suicide is not the final answer to the problems of aging.

Our committee has invited testimony from individuals who can discuss the issue of suicide among youth and young adults. Although we are receiving testimony through the auspices of the Select Committee on Aging, we recognize that senior citizens are concerned about the welfare of the next generation, their children and their grandchildren. They have lived long in this society and want to ensure that the health of the young is not neglected.

The testimony we will receive today is from individuals who can speak personally about the effects upon family and friends when a loved one commits suicide. Others are experts in the field who work with persons in crisis and their families. We will also hear from individuals who have expertise in public policy at the State and Federal levels. In all of your testimony, we will be looking for guidance for Federal policies in dealing with this national problem. We at the Federal level need to know exactly what should be done.

We will begin with the first panel of individuals who will speak personally about the effects of suicide on family and friends.

I would like to state at the outset that during my service in Congress, I have had a lot of witnesses ranging from the Secretary of State to the Secretary of Defense, but I have never felt as humble and as grateful as I am this afternoon to the witnesses here today, because in almost every instance your testimony involves personal anguish on your part; and, on behalf of the Congress and the American people, I want to express my appreciation.

We shall first hear from Dr. Robbie Burnett, who holds a Ph.D. in psychotherapy and is a private clinician in Houston at the International Hospital; and her associate, Mr. Michael Thomas, who holds a master of social work and is a senior psychotherapist at the Houston International Hospital.

We will be happy to have you proceed in your own way. Your written testimony will be placed in the record in full. If you would like to summarize your testimony or read it, that is your choice.

Dr. Burnett.

Dr. BURNETT. Thank you.

STATEMENT OF DR. ROBBIE BURNETT, PH.D., PSYCHOTHERAPIST AND PRIVATE CLINICIAN, HOUSTON INTERNATIONAL HOSPITAL, HOUSTON, TX

Dr. BURNETT. I'd like to just take my time to present primarily the focus on two major areas: The prevalence of suicide among teens, and the need for public awareness. Recently, there has been national attention given to the six suicides in Clear Lake, TX. These suicides were national news due to the cluster and timing and not the event. Had these six suicides been scattered around the State, the Nation, or even just scattered around Houston, they probably would not have been given the notice that they have. It is easier for us to look at a group incident, and rationalize that it must have something to do with that particular area of the county or the city.

This rationale protects us from looking at suicide as a national, local, or a personal problem. "Silence of the Heart" portrayed the aloneness and the individuality of this epidemic. While we know that there is force in numbers, it is an injustice that teen suicide be in the clusters to get our attention.

Since the Clear Lake suicides there have been questions asked: "What's going on over there?" and "What's wrong with those kids?" And the response that we have made is that it is not just "over there" and it is just not "those kids", it is all our kids, everywhere. We need more research grants. We need more understanding in the area. We need more uniform reporting. We need more movies like "Silence of the Heart." We need more public awareness.

In working with the media over the past week, I have found them to be concerned about how much to cover the topic, and concerned about the consequences of covering that topic. This concern seems to coincide with the public idea that too much coverage of teenage suicide will only provoke others. Even the kids in Clear Lake became angry with reporters for coming around, and behind this feeling is anger and fear and ignorance.

Within the past 20 years, our knowledge, our understanding in the area of cancer has increased tremendously and we have made great strides in combatting cancer. Five years ago the general public knew virtually nothing about AIDS. Once greater numbers of people began dying with AIDS, fear, alarm, and ignorance created an urgency to do something about the disease. Moneys became immediately available for research. And today we are getting closer to answers, and the public has been educated effectively on current understanding and knowledge. And all I'm saying is there appears to be a positive correlation between public awareness and effective control.

This week, an article came out in the Houston Post stating major crimes were down. Reason for the decline was contributed to increased public awareness. Let's not keep our heads buried and pretend if we don't talk about it and if we don't hear about it, then it is not happening. Let's get suicide out of the closet. Let's expose suicide for what it really is, an epidemic, a national tragedy.

Let's fight the battle of teenage suicide with the same weapons we use on cancer: knowledge, research, money, understanding, and public awareness.

It is the only chance our kids have. Thank you.

Mr. LANTOS. Mr. Thomas.

STATEMENT OF MICHAEL THOMAS, SENIOR PSYCHOTHERAPIST, HOUSTON INTERNATIONAL HOSPITAL, HOUSTON, TX

Mr. THOMAS. By the time this hearing ends this afternoon we will not be any closer to knowing why young Americans kill themselves. We will not have developed a miraculous formula to combat the most preventable death. In fact, as we meet, across the Nation, within the next couple of hours anywhere between 100, 150 of our youth will attempt suicide. How many will succeed?

The concept of suicide is perhaps as unique as the individual who commits suicide; and there are, perhaps, as many theories as there are theories as to why such suicide occurred.

The uniqueness and the theories, as well as the theorists, must be linked together somehow, somewhere. Therefore, a plea is being made for the establishment of a national centralized computerbank, and I want to take the allotted time that I have to define the deposits into that bank.

We feel that a national computerbank is needed to address, one, reporting. As Dr. Burnett pointed out, a national uniform checklist or questionnaire to render documentation of certain deaths as suicide must be established.

In some municipalities, if an individual dies weeks after a suicide attempt, the death may be recorded as "death due to complications following surgery of a gunshot wound," as opposed to suicide itself.

Two is that an automatic and specified investigation of all accidental deaths to rule out the possibility of suicide. In the movie, "Silence of the Heart," it was obvious to the viewers that it was suicide. However, that death was recorded as an accident.

OK.

A centralized bank will be centrally located and store the following information. Suicides throughout the nation are to be reported on a regular basis to include age, sex, race, method, et cetera.

Major networks, ABC, CBS, NBC, PBS, will be mandated to log air time on public service announcements and documentaries in movies dedicated to the topic of suicide, teen suicide, and to submit the disk time to such a computer bank.

A list of suicide hot lines and suicide prevention clinics throughout the Nation will also be listed at this—within this computer-bank.

The solicitations of private funding and the establishment of foundations for public grants to investigate the subject of suicide is needed.

The solicitation of articles and research projects for private clinicians, and social services agencies ought to be stored in one central location.

The involvement of public role models, professionals, athletes, musicians, entertainers, politicians, et cetera, to do public service announcements, warning or talking about suicide.

To encourage employee assistance programs throughout the American work force, to sponsor periodic lectures and symposiums on suicide and other problems facing you, and to produce full-length documentaries and full-length programs as "Silence of the Heart" for our television audience to talk about and discuss suicide.

And also to establish a working relationship with preexisting agencies such as the American Association of Suicidology, the National Council of Families, the National Council of Juvenile Offenders, the National Council of Child Abuse, et cetera.

OK. The bank is needed to be stored in one location so that all this information could be gathered together, and disseminated at will, OK.

Some of the main objectives of the centralized bank is to reduce reporting area, remove doubt and suspicion from information reported, and to give clarity to information disseminated.

Without those objectives, the goals become ill-defined.

Thank you.

[The joint prepared statement of Mr. Burnett and Mr. Thomas follows:]

PREPARED STATEMENT OF ROBBIE BURNETT, PH. D., AND MICHAEL J. THOMAS, MSW (CSW)

SUICIDE IS NOT THE ANSWER

(Copyrighted May 1977 BY MICHAEL JAMES THOMAS)

You've locked yourself in your own little jail
Because you think and feel that you do nothing, but fail.
Only you can set yourself free.
Because you are the only one with the key

You are here with many, but yet you are all alone
And suicide is not the answer.

Open the door, there is a world outside.
You are already on it, so you may as well ride.
Nothing you can do in which to hide

Not even committing suicide.

You are here with many, but yet you are all alone
And suicide is not the answer.

Upon pulling the trigger,
You just may figure
That when you are dead, you are done.
It'll all be over and nobody would have won.

You are here with many, but yet you are all alone
And suicide is not the answer.

To jump down from some high place,
Could prove to be only a waste.
Did you ever stop to use your head?
I mean, what if there's life after you are dead?

You are here with many, but yet you are all alone
And suicide is not the answer.

If you can't cope, or deal with life,
And you decide to end it by using a knife,
Then your dues for life would be unpaid
What if there's a price to pay, after you are dead?

You are here with many, but yet you are all alone
And suicide is not the answer.

So please my friend, don't take that dive.
Make your life useful, stay alive.
There are so many people who are willing to try
And make you feel like you don't want to die.

You are here with many, but yet you are all alone
And suicide has until yet to be the answer . . .

YOUTH AND SUICIDE: A CLINICIAN'S PLEA FOR HELP

Suicide is currently the second leading killer of young Americans. Until recently, suicide was considered to have been the third leading cause of death preceded only by accidents and homicides. However, if accidents were investigated more carefully and reported more accurately, many clinicians feel suicide would be the number one killer of our youth.

Teenage suicide has increased 300% over the past 2 decades. It has been estimated that 18 children commit suicide daily with 57 attempts hourly and over 1,000 attempts daily. Females attempt suicide three times more than males, however, males are three times more likely to succeed. While all other age groups in our society are surviving illness and living longer, the teenage death rate is rising at an alarming rate. It is speculated that the increase in attempts has risen as much as 3,000% per year.

Recently there has been national focus on Clear Lake, Texas. Within a few weeks six teenagers from the same area killed themselves. These incidences made national news because of the cluster and the timing, not the event. Had these teens not been from the same neighborhood and school district, their deaths would have gone by virually unnoticed. To qualify this point, it's necessary to note that since the "Clear Lake Suicides" there have been three other suicides in the Houston area within one week. None of these made all local network news nor were they given any national attention. From this perspective there is a duel tragedy with teenage suicide: first the young lives lost and secondly the disheartening idea that if it's not done in groups it's not worth talking about. It's a shame that it takes a cluster to be worth mentioning.

The suicides in Clear Lake provoked shock, fear, surprise, and anger among area residents. This community felt alarmed and threatened as though there was something peculiar and unusual happening just in their particular town. Unfortunately, the suicides in Clear Lake, Texas are examples of what's happening accross the United States. Daily, children, adolescents, and young adults are killing themselves.

The clinicians at Houston International Hospital have long recognized the seriousness of teenage suicide. However, efforts to educate the community through public speaking and hosting workshops have been somewhat frustrating. Until the Clear

Lake tragedy, our message had been falling on deaf ears. Teachers, administrators and parents seemed unaware of the epidemic and appeared ambivilant about hearing presentations on suicide. Now that so much attention has been focused on Clear Lake, people are scared, curious and ready to listen. However, if the public's attention is not capitalized upon immediately, Clear Lake and teenage suicides will be forgotten until a new cluster occurs.

There are perhaps as many theorists as there are theories as to why the rate of youthful suicide is as high as it is. Some clinicians look at the demise of the extended family. The extended family may offer aunts, uncles, grandparents and peers as sources of affection, attention and support in times of need. Aside from broadening the child's support system, the extended family offers additional role models. Within the same vein, it has been documented that aside from the breakdown of the extended family, one in every two marriages ends in divorce and three of every five divorces involve children. Research also suggests that the nuclear family is far more mobile than ever before. The average length of time the nuclear family remains in one locale is estimated to be five years. Economic reasons as well as job security have been cited for this statistic. The question of quality versus quantity of time that parents spend with their teenagers has also been raised. One investigation of intact families concluded that the average time that fathers spend with their teenage children is about 37 seconds per day.

Other clinicians have cited coping mechanisms that youth are acquiring in the absence of an "adequate" support system. A recently released Nielsen study revealed that the average household with children watches TV 49 hours per week witnessing countless TV murders. "Sex, drugs, and rock-n-roll" has become something of an anthem for America's youth. The message of most rock-n-roll songs are about sex and drugs. Some even suggest suicide and/other modes of self destruction. Most people, especially children and adolescents, oftentimes do not fully understand the finality of suicide. They choose suicide when what they really want is (1) not to feel hopeless; (2) not to experience as much self-hatred or; (3) to get back at someone. They sometimes do not realize that if they commit suicide, they are going to be dead!

Other areas of focus are on the effects of loss. Young Americans basically have a limited frame of reference to cope with loss. For example, when a 16 year old finds himself/herself involved in their first "serious" relationship and the relationship abruptly ends, they may perceive this to be the end of their world. They have no reference on past similar experience to draw from to assure them that things will be okay. Adults may view such a romance as puppy love and tend to minimize the devastating effect it is having on a 16 year old.

Whatever the reason or whatever the focus, all can rest assured that youth suicide is on the rise in America and is virtually robbing the precious lives of our children. Whatever the reason, 1,239 youth suicides were reported in 1960. Whatever the reason, in 1970 the number of suicides was 3,128 up by 1,889 from 1960.

Whatever the reason, the number of suicides recorded for 1980 was 5,239 up 300% since 1960. Today it was Clear Lake, yesterday it was Plano, before that it was Westchester County and Chicago. Tomorrow who knows where it will be? But what we do know is that it will be.

RECOMMENDATIONS

1. Reporting
   - A. A National uniform checklist/Questionnaire to render documentation of certain deaths as suicide
   - B. An automatic and specified investigation of all accidental deaths to rule out the possibility of suicide

II. Centralized Computer Bank
   - A. The bank is to be centrally located and store the following information:
     1. Suicides through the nation are to be reported on a regular basis. (To include age, sex, race, method, etc.)
     2. Major networks: ABS, CBS, NBC, PBS will be mandated to log air time of public service announcements, and documentaries dedicated to the topic of suicide/teen suicide and to submit to computer bank on a regular basis
     3. A list of suicide hot lines and suicide prevention clinics throughout the nation. (A working relationship with these establishments should be constructed)
   - B. The solicitation of private funding and the establishment of a foundation for public grants to investigate the subject of youth suicides.

1. The solicitation of public grants (Federal, State, Local) for the establishment of "wellness" clinics stressing preventive psychiatric concepts. These programs would stress effective parenting, communication skills for child and parent, use of surrogates to make up for the absence of an extended family.

C. The solicitation of articles and research projects from private clinicians and social service agencies to be stored at a central location

D. The involvement of public role models; professional athletes, musicians, entertainers, politicans, etc. to do public service announcements

E. To encourage Employee Assistance Programs throughout the American work force to sponsor periodic lectures and symposiums on suicide and other problems facing youth

F. To produce full length documentaries made for television depicting suicide

III. Establishing a working relationship with pre-existing organizations such as:

A. American Association of Suicidology

B. National Council on Families

C. National Council on Juvenile Offenders

D. National Council on Child Abuse

THE NEED FOR A CENTRALIZED COMPUTER BANK

Before establishing a centralized computer bank, deposits if not withdrawals must first be defined. Therefore, first and foremost, the authors of this paper call for a national uniformity in reporting. The death of children from affluent families may be recorded as an accident to save the family from embarrassment and humiliation and to avoid any stigmatization. Statistics of individuals who succumb to life a week or so after a suicide attempt may be recorded as an accident or "death due to complications of surgery following gun shot wound to the head" or anything other than what it actually is; suicide.

In some states or municipalities, if an individual who hangs himself/herself is found with particles of his/her skin underneath their fingernails, the death may be recorded as an accident with the rationalization that the individual realized the consequences of their actions and changed their minds, then they attempted to remove the noose.

The establishment of a uniformed method of reporting suicides would lessen the deleterious effects and give clinicians and researchers a truer picture of what they are actually confronted with.

Now that the proposal for the definition of deposits into the bank has been submitted, let us now explore the construction of the centralized computer bank itself. The concept of suicide is perhaps as unique as is the individual who commits suicide. It is felt that the collection of this uniqueness could and would yield a commonality from which viable inferences could be drawn. As it stands, inferences are already being drawn, and if it is drawn from misinformation or inaccurate information, as is the case with faulty reporting, it brings clinicians and researchers farther from the solutions and simuitaneously complicates the problem.

Some of the main objectives of a centralized bank is to reduce reporting error, remove doubt and suspicion from information reported and give clarity to information disseminated. Without those objectives the goal becomes illdefined.

Mr. LANTOS. Thank you very much.

We next hear from Ms. Iris Bolton, who is the mother of a teenage suicide victim and is now a counselor at the Link Counseling Center in Atlanta, GA. She is the author of an outstanding book entitled "My Son, My Son."

Ms. Bolton.

STATEMENT OF IRIS BOLTON, MOTHER OF TEENAGE SUICIDE VICTIM; DIRECTOR, LINK COUNSELING CENTER, ATLANTA, GA; AND AUTHOR OF "MY SON, MY SON".

Ms. BOLTON. Thank you.

I come to you both as a professional and as a parent who has experienced the suicide of our 20-year-old son.

My husband and I had been married 31 years, and 7 years ago, we lost our son, 20, Mitch, who chose to end his life by shooting

himself with two guns. He was determined that he was not going to fail in the last act of his life.

When one experiences a suicide in the family, that family becomes that risk for suicide—the friends, the teachers, the minister; everyone who knew that family becomes at risk.

I have written my story of surviving, and that is a choice. In the book "My Son, My Son," encouraged to do so by a professor at Emory University who said, "Don't write a thesis; just write a book about survival; that's what we need."

My family has chosen to survive, and I think that is a choice. But as I have chosen, and my family has chosen to survive, what I have found is that many, many people have come to the Link Counseling Center, which is a family center for individuals, couples, and families; it is a private nonprofit center; and we deal with all kinds of family issues. And one of the issues that we are dealing with more and more today is suicide.

And what happens now is we are getting families coming to us, saying, "My husband, my wife, my mother, my father, my sister, has chosen to die, and I don't want to go on living."

We are requested to come to the schools and talk about this phenomenon—No. 1, prevention. What do we do to prevent it, if anything? What are the signs that we look for? Intervention? What do we do when we see those signs? And where do we go to get help?

Postvention, meaning how do you help the youngster who has attempted and many many more attempt and do not complete.

How do you help them get back into the school system and have a productive life and deal with the stigma of suicide?

And how do you help the family go on living and surviving? We have requests from schools to come into the class and look at the postvention, of helping that family, those teachers, those students, survive.

When a suicide occurs, I have spoken to a thousand kids in assembly at one time, to deal with a number of issues. No. 1, the problem, the awareness of the problem.

No. 2, their response. They first feel confusion. They want to know why, and then they feel anger and rage, enormous anger. How could this be? What a dumb thing to do.

Then they may feel guilt. What did I not do or do? Why did I tease her yesterday? Why did I trip him in the hall?

Then, this is probably the most important phenomenon, the feeling that they feel, which is a sense of—I guess if this is what growing up is all about, I don't want to grow up either. If this is what it's like, then I want to die too.

So, the thoughts of suicide become very natural and very normal to them, and they don't know that it's natural and normal. They think: "I'm going to kill myself too." That has to do with this contagion effect, because youngsters don't know that there are some people who think about it, some who threaten, some who make gestures, some who attempt, and some who complete.

So, when they begin to see a suicide, and they begin to think about it, they also think: "I'm going to kill myself. Life isn't worth living."

So, when I talk to a whole student body, there is a sense of relief, and when I tell them that I know what it is to feel the pain, and to

go through these emotions, they all know that I know what they are feeling, and there is a sense of relief. You can see a thousand kids almost breathe a sigh of relief: "You mean it is normal to think of dying. I don't have to kill myself."

And one student came to me afterwards, and said: "But I have thought of dying and killing myself; you mean I am not crazy."

And I said, "How often do you think about it?"

And he said, "Well, I guess a couple of times a year, you know, when report cards come out."

And I said, "No, it sounds like you are fairly normal to me; but if you think about it a lot, then you need to know that you need to talk to someone."

Kids don't have permission to talk to other people. They want to keep it inside. They want to look perfect, so there are a number of things that I think we need to do in the schools. We need this National Commission to focus attention, to give money on research, and programs in the community; to be a national clearinghouse, where we can get information from a central place.

Right now, it is happening all over the country, but we don't know where it is. We don't know where the manuals are; and we need those resources; we need to increase awareness of the problem in the Nation. We need to educate as the predictors and the signs of suicide, and most people give the signs; we just miss them because we don't know them. We are not trained.

My son gave the signs that we didn't know were signs of suicide; we thought they were merely signs of grieving, of breaking up with his girlfriend.

We need to educate as to the crisis intervention techniques. We need to promote awareness of community and statewide resources in the community. We need to educate what the grief process is, because most suicides occur after a loss. It could be a loss of a girlfriend/boyfriend, loss of face, loss of a loved one, of a relationship, breaking up with a girlfriend/boyfriend, or loss of a life.

We need to develop schools that have programs that deal with life management skills such as positive self-esteem building, communications skills, relationship building. How do you get in? How do you maintain it? And how do you get out of it? Without destroying one another.

The process of grief around loss.

Teaching positive failure; that it is not the failure that is important, it is what you learn from that failure.

Teaching the meaning and letting them discuss the purpose of life and death, the meaning of all of that.

Avoiding loneliness and isolation.

Building support systems. How to connect to other people and to develop stress management skills.

It is my hope that as we struggle with this desperately difficult problem, and we realize that the statistics are much greater than they are, it is my hope that we will all unite in our effort to fight the problem. It is a health problem. It is the No. 2 leading cause of death of young people and the highest increasing of all ages.

So, we must struggle together. We must spend dollars, because that is the way research will come.

And I will close by sharing what I have written in my book, which says:

I don't know why. I'll never know why. I don't have to know why. I don't like it, and I don't have to like it. What I have to do is make a choice about my living, and what I do want to do is accept it and go on living. The choice is mine. I can go on living valuing every moment in a way I never did before, or I can be destroyed by it, and, in turn, destroy others.

I thought I was immortal, that my family and my children were also; that tragedy happened only to others, but I now know that life is tenuous and valuable, so I am choosing to go on living, making the most of the time I have, valuing my family and friends never possible before.

So, as we come into this 2-day conference on teenage suicide, I hope that we will all begin to share and learn how we can prevent it, how we can intervene, and how we can help those of us survive this tragedy.

[The prepared statement of Ms. Bolton follows:]

PREPARED STATEMENT OF IRIS BOLTON, DIRECTOR THE LINK COUNSELING CENTER, ATLANTA, GA

Suicide may be prevented by developing a prevention program with the following goals:

1. To increase awareness of the problem of suicide among youth through education of students, teachers, counselors, principals, clergy, juvenile justice workers, mental health professionals, and families.
2. To educate as to predictors of the signs of suicide so as to prevent attempts and reduce the numbers of completed suicides.
3. To educate as to crisis intervention techniques.
4. To promote awareness of community and statewide resources including mental health centers, private and non-profit agencies, poison control, tie-line, etc.
5. To educate as to the grief process following a suicide for friends, family, teachers, peers, clergy, etc. so as to support grieving individuals and minimize the stigma and frequent "contagion" effect of suicide.
6. To develop a program within the schools which deals with:
   a. Positive self-esteem
   b. Communication skills
   c. Relationships—getting in, maintaining, and getting out appropriately
   d. Process of grief around loss
   e. Positive failure/positive success
   f. Life skills, i.e., decision-making, values clarification, problem-solving
   g. The meaning of life and death
   h. Avoiding loneliness and isolation—by building support networks
   i. Stress management
7. To develop a training package to be replicated statewide to mobilize communities to preventive efforts against the incidence of suicide through:
   a. A trainer of trainer's manual
   b. Audiovisual aids
8. To conduct statewide workshops using manual and audiovisual aids to leave communities with resources of their own.

Most people do not want to die. They are usually ambiguous up to the last moment of decision. Often suicide attempts are a means of communication indicating intense despair and pain. Many people are crying out for help and feel unable to be heard any other way. It is up to all of us as concerned citizens to be aware of the problem of suicide, to learn about available resources in our community and to give those individuals considering suicide the support, love, and direction which might shift the balance toward the decision to live. Unless we as a caring community take steps to impact the complex problem of suicide, we will continue to lose thousands of our citizens annually.

The gift of human life is important and the widening ring of tragedy of suicide leaves behind devastation and pain. No amount of technology, education, and funding can substitute for a willing, patient ear and empathy on the part of every human being for every other.

References: "Special Report . . . . SUICIDE MORTALITY, 1977–1979." A publication of the Health Planning & Statistics Unit, Ga. Dept. of Human Resources, Div.

of Public Health, May 1981. "About Suicide." A Scriptographic Booklet by Channing L. Bete Co., Inc., South Deerfield, Ma. 01373, 1979.

Mr. LANTOS. Thank you very much, Ms. Bolton.

Out next witness is Mr. Jack Hovingh, a nuclear engineer at the Lawrence-Livermore Laboratories in Livermore, CA., and the father of a suicide victim. We are very grateful to you for coming, Mr. Hovingh.

Mr. HOVINGH. Thank you.

STATEMENT OF JACK HOVINGH, NUCLEAR ENGINEER, LAWRENCE-LIVERMORE NATIONAL LABORATORY, LIVERMORE, CA, AND FATHER OF YOUTH SUICIDE VICTIM

Mr. HOVINGH. I would like to thank Representative Tom Lantos, and the other attendees for your interest in youth suicide, and especially during a busy election campaign.

I would like to break my statement up into several parts, and I will abbreviate the statement.

First is my motivation for testifying, and second my perception of the problem of youth suicide, and finally some recommendations.

These are strictly my own opinions. I am not a social scientist and no expert, but I am hopeful there will be a germ for some ideas there.

The motive for this testimony is that I am a victim of a suicide. On December 15, 1983, my son, Mark Alan Hovingh, took his own life at the age of 23, leaving as victims his sister, mother, grandparents, uncles, aunts, and a cousin.

Mark was a superbright, supersensitive young man, who loved, and was loved and respected by many. And he knew he was loved, and we knew that he loved us.

If Mark had only thought, he would have realized the grief he would cause those people that he loved the most; and he may not have committed suicide.

Mark was my son, but more important to me, he was a sounding board for ideas; he was a confidante; he was my ski partner; my chess opponent, and to summarize, perhaps, my best male friend; and I miss him.

Youth suicide is a national problem. In Mark's class, in a small elementary school in Castro Valley, at least two students, one being Mark, in a group identified by tests as being "mentally gifted minors" committed suicide.

I am aware of at least two of my professional colleagues whose sons committed suicide.

These men were truly part of the best and brightest, who could have, had their death been prevented, contributed much to the health and welfare of our Nation.

While these youths were part of the best and brightest, the loss of any youth represents in my opinion a loss to the Nation.

At a time when the average age of the citizens in this country is increasing, we can ill afford this loss of their potential contributions of these young people to the arts, sciences, services industry, wealth, and defense of our Nation.

Another part of the national problem of youth suicide is the loss of productivity due to the effects on the health of those other victims of suicide, the survivors.

Mark's sister, Mary, formerly a vivacious, success-oriented woman who loved her brother very much, has suffered poor mental and physical health since his death, which has affected her personal and professional life.

These effects, while perhaps temporary, but taken in the whole, are detrimental, in my opinion, to the welfare of our nation.

In the pure economic sense, our society has invested a great deal of time, talent, and money, in the education of our youth, with a full expectation that it will receive a return on this investment.

Youth suicide prevents a return on the social investment in the victim. Thus, in my opinion, it is of national interest to prevent suicide and it is logical for the Federal Government to finance in a large part programs designed to prevent suicide.

If the Federal Government does involve itself in youth suicide—and I hope it does—the vast majority or the funds should be directed to preventing suicide, not studying the causes of the suicide. We all know the causes of suicide: the victims perceive themselves as failures in anything important to them—school, relationship with the person of the opposite sex, family members or friends, their jobs, their lack of a job and so on.

Any study of the causes of suicide should be in support of the prevention program—designing programs, defining new programs, redirecting programs, and measuring success of the prevention programs.

In my opinion, programs should be emphasized that committing suicide is not "cool." Success is obtained by overcoming failures. Suicide is a last resort of a coward.

I am sure that the sociologists and psychologists can design messages to get across to people with low self-esteem, that suicide is not OK.

These messages can be designed with inputs from the youth. Many professionals forget what it was like to be young. The programs to prevent suicide should be designed for radio stations, and regular television and cable channels, especially the MTV channels—music television channels.

These programs should consist of 1-minute spots, required by the FCC to be broadcast during the times the young people listen to the radios or watch television.

Additional programs should be designed for the schools to be used in required courses such as health, physical education, drivers' education, or Government.

The funds for the school program should, in my opinion, be furnished by the Federal Government.

Crisis centers and suicide hot lines, currently exist in many parts of the country. Much of their resources are based on the time of volunteers and tax deductible contributions. The existence, however, should be more widely publicized, and their resources should be backed by a stable source of funds that is independent of the economic conditions in an area.

These funds should come from the Federal Government.

I recognize that no program, however well designed, is totally successful. Thus, I would like to see a network of that other victim of suicide, the survivors, to be able to communicate their feelings, frustrations, and experience to others that have experienced this relatively unique experience.

This network is most important for the siblings of the suicide victim. I believe that this could be done without Federal support, but may require a minimum State and/or local suport.

This network would result in a potential mitigation of the deleterious effects of a suicide on the mental and physical health of survivors.

Mark Alan Hovingh is immortal in the many good deeds that he did for his friends—and even strangers. These deeds will live on, forever. Even with his death, his life had meaning, because his death opened up communications between young adults and their parents in several families of which I am aware.

Had Mark decided to live, however, he could have done much more for this Nation; but if his death and the action of others will result in saving more lives, then his death was not in vain, but served a useful purpose in the big picture for this Nation.

[The prepared statement of Mr. Hovingh follows:]

PREPARED STATEMENT OF JACK HOVINGH, PLEASANTON, CA

My name is Jack Hovingh from Pleasanton, California. I would like to thank Representative Lantos and the other attendees of this meeting for their interest in youth suicide. I would like to break my statement into several parts: My motive for testifying; The Problem of Youth Suicide; and Recommendations.

My motive for this testimony is that I am a victim of a suicide! On December 15, 1983, my son, Mark Alan Hovingh, took his own life, at the age of 23, leaving, as victims, his sister, mother, grandparents, uncles and aunts, a cousin, and many friends. Mark was a super-bright, super-sensitive young man who was loved and respected by many. He knew he was loved (my last words to him the last time I saw him alive were "Mark, I love you. Be cool!") and he loved us (his mother, sister and I all received a note saying simply, "I love you"). If Mark had only thought, he would have realized the grief he would cause those people he loved the most, he may not have committed suicide. Mark was my son, but more important to me, he was a confidant, sounding board for ideas, my ski partner, my chess opponent—best male friend. I miss him!

Youth suicide is a national problem. In Mark's class in a small elementry school in Castro Valley, California, at least two students (one being Mark) in a group identified by tests as being mentally gifted minors committed suicide. I am aware of at least two of my professional colleagues whose sons committed suicide. These young men were truly part of the "best and the brightest," who could have, had their deaths been prevented, contributed much to the health and welfare to our nation. While these youths were part of the "best and the brightest," the loss of any youth represents, in my opinion, a loss to the nation. At a time when the average age of the citizens in this country is increasing, we can ill afford this loss of their potential contributions to the arts and sciences, services and industry, wealth and defense of our nation.

Another part of the national problem of youth suicide is the loss of productivity due to the effects on the health of those other victims of suicide—the survivors. Marks sister, Mary, formerly a vivacious, success oriented woman who loved her brother very much, has suffered poor mental and physical health since his death which is affecting her personal and professional life. These effects, while perhaps temporary, but taken in the whole, are detrimental to the welfare of our nation.

In the pure economic sense, our society has invested a great deal of time, talent and money in the education of our youth, with the full expectation that it will receive a return on this investment. Youth suicide prevents a return on the social investment in the victim. Thus, in my opinion, it is of national interest to prevent suicide, and logical for the federal government to finance, in a large part, programs designed to prevent suicide.

If the federal government becomes involved in youth suicide, and I hope it does, the vast majority of the funds should be directed to preventing suicide, not studying the causes of suicide. We all know the causes of suicide—the victims perceive themselves as failures in something important to them—school grades, a relationship with the person of the opposite sex, a family member or friend, their job (or a lack of a job), etc. Any study of the causes of suicide should be in support of the prevention program—redirecting the program, defining new programs, and measuring the success of the prevention programs.

In my opinion, programs should emphasize that committing suicide is not cool—success is obtained by overcoming failure—suicide is the last resort of a coward. I am sure that the sociologists and psychologists can design messages to get across to people with low self-esteem that "suicide is not OK!" These messages can be designed with inputs from the youth—many professionals forget what youth was like.

The programs to prevent suicide should be designed for radio stations, and both regular television and the cable channels, especially on the MTV channels. These programs should consist of one minute spots and be required by the FCC to be broadcast during the times young people listen to the radio, or watch television. Additional programs should be designed for the schools to be used in required courses such as health, physical education, drivers education or government. The funds for the school programs should be furnished by the federal government.

Crises centers and suicide hot lines currently exist in many parts of the country. Much of their resources are based on the time of volunteers and tax deductible contributions. Their existence should be more widely publicized, and their resources should be backed by a stable source of funds that is independent of the economic conditions in the area. These funds should come from the federal government.

I recognize that no program, however well designed, is totally successful. Thus I would like to see a network of that other victim of suicide—the survivors—to be able to communicate their feelings, frustrations and experiences to others that have experienced this relatively unique experience. This network is most important for the siblings of the suicide victim. I believe this could be done without federal support, but may require a minimal of state and/or local support. This network would result in a potential mitigation of the deleterious effect of a suicide on the mental and physical health of the survivors.

Mark Alan Hovingh is immortal in that the many good deeds he perfromed for friends and even strangers will live on—forever. Even with his death, his life had meaning because his death opened up communications between young adults and their parents in several families of which I am aware. Had Mark decided to live, he could have done much more for this nation. But if his death, and the action of others, will result in saving more lives, then his death was not in vain, but served a useful purpose in the big picture for this nation.

Mr. LANTOS. Thank you very much, Mr. Hovingh.

I wonder if I might ask all four of you to stay here for just a few moments, because I have a number of questions. Let me first say how deeply moved and impressed—and I am sure we all are—by your the testimony.

Let me talk a little bit about Clear Lake, Dr. Burnett. Mr. Thomas, tell those of us who really have only a very sketchy knowledge of what happened at Clear Lake, what happened, and on the basis of the investigation that has gone on thus far, what is the preliminary judgment as to why this sequential pattern of suicide took place in this community?

Dr. BURNETT. Well, what happened was that there were six suicides within—approximately 2 months.

Mr. LANTOS. Yes.

Dr. BURNETT. The reaction by the community, the reaction by the school district and by the children and the families, every—it's shock, it's surprise; it's like there is a sudden awareness of what's going on everywhere else, but they don't know that it is going on everywhere else, so they are alarmed.

Nobody knows why. They don't know why. They are not guessing at why. What they are saying is the things that you have heard all four panelists say, is that we need more centralized information.

The parents are saying——

Mr. LANTOS. We agree with you on that, and the purpose of my legislation is precisely that. The legislation which will be reintroduced in January establishes a Federal Commission on Suicide to find out the causes, and it will provide for matching State grants for states that have effective prevention programs and other programs.

But I suspect there must have been a great deal of questioning that led to some tentative conclusions as to why in that small community within a span of very few weeks you have had a whole series of suicides.

Dr. BURNETT. Well, there has been speculation.

Mr. LANTOS. Give us some of that speculation.

Dr. BURNETT. That's a very wealthy community. There's a lot of professional people there. They figure that the pressures and the stress that the kids are involved in had something to contribute to the number of kids killing themselves.

There was also the idea of the pact—that the kids had come up with a list of about 20 people that had made a commitment to kill themselves.

We have found that to not be the case, so I don't think we are dealing with a pact in Clear Lake.

Did I answer your question?

Mr. LANTOS. Well, you are beginning to answer the question.

Let me first ask specifically, what was the relationship, if any, between the first victim and the others?

Mr. THOMAS. OK, Dr. Burnett and I attended several sessions out at the Clear Lake area.

Initially, it was reported that there was no connection, that the students didn't know each other. However, at one session we attended a student did stand up and say he knew personally three of the victims that committed suicide. So, they did have some connection with each other outside the regular school center.

Mr. LANTOS. Is the community doing anything now to prevent a continuance of this pattern?

Mr. THOMAS. As Dr. Burnett mentioned, it was a shock, and perhaps shame. It's a small private bedroom community, a pretty affluent community.

Robbie and I have been out doing a lot of peer counseling. Clear Lake High School has been pretty receptive to letting us conduct a class on peer counseling in terms of recognizing the signs and symptoms of suicide, and the crisis intervention type techniques.

Dr. BURNETT. I thought this was real commendable on the kids' part. They themselves want to know what to do, instead of just what should the parents do?

What should the school district do? They are wanting to know what they can do to help; and teaching them how to do peer counseling, I thought, was an excellent idea of the schools.

Mr. THOMAS. They pretty much had the same attitude as did, I think, the girl's name was Cindy in "Silence of the Heart"—they were pretty enthusiastic about what was going on. They are par-

ticipating in psychodrama, and role-playing exercises, in terms of counseling their peers.

Mr. LANTOS. Ms. Bolton, I would like to ask a couple of questions of you. Again I want to express our appreciation for your willingness to speak about a subject that is so difficult for you. What signs, in retrospect, do you think you could have picked up, should have picked up?

Ms. BOLTON. Primarily a change in my son's behavior. We attributed that to his breaking up with his girlfriend, or her breaking up with him. So, we thought he was in natural grief about ending a long-term relationship.

Looking back, there was a sign—we leave notes, as a family, where we're going, what we're doing. There was a card on the counter one Sunday morning that said, "Dear Mom and Dad, thanks for making a lot of hell a little bit of heaven."

That, we thought, meant because he was grieving because we had talked with him about his feelings about being left by this girl, though it was not her fault. That was simply a trigger in a long series of events that he perceived as failure.

I think suicide is caused—if we know anything, we believe it is caused by an accumulation of things that build and build and build, never by one event alone.

But it was probably triggered by that event, plus an event that he had worked in a department store and was embarrassed; his pants were split one day when he leaned over. And he came home and laughed about it, but it wasn't funny. When he went down the hall, I heard him making some remarks that were not funny; and then I think that the last day he had bought ice cream for the family. He was a sunshine and tears kind of young man. Everything was either wonderful or down.

The changing behavior from being so generous with his money and buying ice cream for the whole family—he had a dark look in his eyes. He did say to me, when I followed him down the stairs. I said, "Are you OK?" because he had a dark look in his eyes; and I said, "Are you OK?" and he said, "No worse than any other night."

If I knew then the signs I know now, I would have probably pursued that. What did he mean by that?

I thought it meant because of the loss of his girlfriend. I was looking narrowly at that one event as being the focus of it; so those kinds of signs, thinking of his saying something like "There isn't any point in going on with life."

He said to his girlfriend: "Who is the most important person in your life?" on the phone, and she said—this is after they had broken up; this was the day of his death, and she said to him, "Well, I have to be the most important person in my life." Which anyone might have said.

And he said, "I can't live with that. I will be a star in the sky and watch over you," at which point he pulled the trigger, while she was on the phone.

The signs that I think all of us saw, the change in behavior; he wasn't sleeping; he wasn't eating. Talking about not being here in the future; talking like he had been a failure. He and I had a talk 3 hours long, the week before. If I had known those signs, had been more aware of those signs, perhaps I could have picked that up.

We talked about his breaking up, and that perhaps now he could spend more energy just on his own career and what he wanted to do with his music, and his sensitivity.

But I didn't pick up on that other than to just have that long talk about life and relationships and success and failure and all that.

He was a young man that could not fail. Success was the biggest thing in his life, that he pushed on himself, that our culture pushes on. We are an achieving family. Our example was accomplish, find meaning and purpose in life and that's fulfillment.

But somehow all of that together—he could not give himself permission to fail. He was a musician, wrote beautiful music; he had found a recording contract the week before he died, and he said to one of his girlfriends, "If this succeeds, how do I know I can write another album. I know I've got one in me, but what if it succeeds, how do I have a second?"

He also said, "What if it fails?"

He feared failure, so I think all of that is in there; so the signs are recognizable. If I had known then what I know now, at least I would have had the opportunity. That might not have saved his life. But at least I would have had the opportunity to say to him, directly, are you thinking of giving up on life? And if you are, let's get professional help. I am your mother; I cannot be your counselor.

I think that is what he would have hoped. I could have had the opportunity to say, "Let's get help." That's the smart thing to do here. That's not negative; that's positive.

So, changing attitudes about getting help is very important for kids.

Mr. LANTOS. Mr. Hovingh, both you and Mrs. Bolton have learned a great deal about this subject, following these events in your own lives from many sources. Knowing now what you do, do you feel that had you known all this about suicide, which you have been forced to learn in the last period, could you have done something to prevent this event?

Mr. HOVINGH. I am not sure. I can't think of anything that I could have done. This came very sudden on me. My son was not—he was living with several other——

Mr. LANTOS. Yes.

Mr. HOVINGH [continuing]. So he was not living at home.

The next to the last time I saw him, he came by on a Friday evening to pick up his skis. He was really in an "up" mood. He told me that, if he ever had kids, he would like to be a father to them like I was to him.

He was really up that night. I think Mrs. Bolton's discussion on mood swings was probably appropriate. I didn't pick up on it. He went skiing up in the Sierras. When he came back on a Monday evening, he dropped by to wash his clothes. I left to go to a city committee meeting, but the last thing I said to him that evening was "Mark, I love you. Be cool." He seemed all right. But he'd been having some trouble with a woman friend, and apparently they broke up on a Tuesday; he decided to commit suicide on a Wednesday, and performed it on a Thursday.

He was also unemployed at the time, and he was concerned about what he was going to get the family for Christmas for Christmas presents.

The accumulation of events, I think, was more than he could tolerate.

Mr. LANTOS. May I address perhaps my last question to all four of you. In these individual suicide cases that we have been talking about, the group at Clear Lake and these episodes, has there been any history of suicide within the families in each of these cases?

Dr. BURNETT. As far as what I am aware of no.

Mr. THOMAS. To my knowledge, there has been a history of loss in several of the cases——

Mr. LANTOS. A history of what?

Mr. THOMAS. Of loss, as in the—Ms. Bolton was bringing out, divorce. Mrs. Shivers, who has been on national television, and the father of her son who committed suicide, was divorced, I think, when he was five; and he has experienced that loss, and has been sharing that with her periodically throughout the years.

Mr. LANTOS. Mrs. Bolton.

Ms. BOLTON. In our family, no, there was none.

Mr. LANTOS. There was none?

Ms. BOLTON. Absolutely not. And I think what happens is—and what happens in communities where there seems to be a series of suicides is that one suicide triggers another. It doesn't cause it. It triggers it. The things have to be there already, all of the accumulation of events have to be already within that individual.

A lot of these kids are impulsive, and they don't realize that suicide is a permanent solution to a temporary problem; and everything is immediate. They want everything yesterday, and they don't realize that thinking of suicide is fairly common and fairly normal.

So, they then interpret if they have the thought because someone else has done it; it's like, uh-oh, I am really crazy; I guess I will kill myself.

And they need to have those thoughts normalized. I think if my son had known that lots of people think about it and do not choose to die, that he might have been able to deal with his problems a different way.

Mr. LANTOS. Mr. Hovingh?

Mr. HOVINGH. In my case, my son's mother and I were divorced at the time Mark had been living with me up until about the time he turned 21. I think he was 16 when we were divorced.

Second, yes, there was a suicide in the family. My mother's brother at the age of 21, I believe—it was before I was born, anyway, also committed suicide.

Mr. LANTOS. Did you learn any of the possible reasons for that suicide?

Mr. HOVINGH. No. In fact, it was very seldom discussed. My grandmother was a strong Dutch Calvinist, and to her suicide was a mortal sin, and we did not discuss it.

My father gave me a little bit of insight and said, he didn't know what caused it, but that indeed it was suicide; the young man had been under a psychologist's care and that was also verboten in that region of the Bible Belt that I grew up in.

Mr. LANTOS. Now, let me—yes, Ms. Bolton.

Ms. BOLTON. One other comment that may be interesting to you, is that I lead a support group for survivors of suicide. One called Compassionate Friends, which is for parents of lost children, by any means—accident, murder, suicide or whatever; and another one, "Survivors of Suicides."

And there is a woman there who has four suicides in her family. She is 75 years old. Her son completed suicide; her husband; her cousin; and her brother.

She came into the Link Counseling Center, and said, "I have had four suicides in my family, and I am not going to be the fifth."

She has a grandson that she is very concerned about, and what we are doing right now is working with that grandson, to help him understand that suicide is not inherited, that it becomes a role model for behavior of solving problems, and that there are many other solutions to solving problems than suicide.

And once people understand that, then they don't have to predict their own death by suicide, just because it occurred in the family. It may trigger it; it may be a role model; but this family is now doing very well understanding it is not inherited, that there are other options to solving problems, and that is what kids need to know.

Mr. LANTOS. Are any of the four of you interested in making a final statement before I call up the next panel?

[No response.]

Mr. LANTOS. If not, let me express my very deep appreciation to you. We do hope your schedule will allow you to stay because we expect some very important additional testimony. I want to thank you very much for being here.

I would like to ask the next panel to come up please:

Ms. Charlotte Ross, director of the Suicide Prevention and Crisis Center of San Mateo County.

Dr. Robert Litman, of the Suicide Prevention Center of Los Angeles.

Dr. Jay Muccilli, psychologist and uncle of a teenage suicide victim, of San Jose.

Patrick Arbore, geriatric counselor and researcher at the San Francisco Suicide Prevention Center.

Julie Perlman, who will present testimony for Dr. Lannie Berman, president of the American Association of Suicidology.

And Melissa Kohn, who is a student at the University of California at Berkeley; friend of a suicide victim and a volunteer in a crisis center.

I am very pleased to have you here. If you have written testimony, it will be entered into the record in full. We would appreciate your proceeding and summarizing your testimony, and I am delighted to begin with Charlotte Ross.

STATEMENT OF CHARLOTTE ROSS, DIRECTOR OF THE SUICIDE PREVENTION AND CRISIS CENTER, SAN MATEO COUNTY, CA

Ms. ROSS. I guess I'm wondering if there is anything that—I am not sure that there is anything that I haven't already said on the

subject, but I would like to just very, very briefly begin the comments to this panel——

Mr. LANTOS. Would you move the mike a little closer to you so we can all hear?

Ms. ROSS. Is that better?

Mr. LANTOS. That's OK.

Ms. ROSS. We've heard from families, and we are hearing now for mental health professionals, people involved in the field, and there are some interesting things that I think are happening in this country in dealing with suicide.

It had been sort of given over to the professional care givers, and now we are hearing families speak out; and there are many elements coming together.

We have parents, youngsters themselves, and now we are looking to the Federal Government to say what is, what can be the policy and position of our Government regarding this loss of our citizens.

I think the thing that we are dealing with today is that we value the resources of this country, and there is obviously no greater resource of this country. What we are looking for——

Mr. LANTOS. Can you pull it a bit closer because I think they have trouble hearing you in the back.

Ms. ROSS. I really want to simply address our comments to what all of us together as a team—care providers, families, survivors, even the despairing can do with our Federal Government toward bringing about a change.

We have been looking at numbers stubbornly unchanging numbers and in some age groups tragically increasing numbers have used suicide. I am hoping that this hearing and other hearings like this are going to herald a great change. I think the 1980's are going to show that one country can do a great deal to reduce your suicide. You've asked some very interesting questions, Congressman. You've asked about suicide and families, and you've asked could we see, and what could we do about it?

I think you and a lot of people in this room are learning a great deal. There is so much—there is so much that can be done, done rapidly if we pull together, and so many lives can be changed.

I am going to really halt my comments and let the rest of the panel tell you what we think can be done with your help, to save, not just a few, but many, many lives in a decade and in the many decades ahead.

Mr. LANTOS. I did have some questions to ask of you, but we will turn now to Dr. Robert Litman.

Please proceed.

STATEMENT OF DR. ROBERT LITMAN, SUICIDE PREVENTION CENTER, LOS ANGELES, CA

Dr. LITMAN. I'm Robert Litman, M.D., a psychiatrist. I have been practicing in Los Angeles since 1950. I am clinical professor of psychiatry at UCLA, long-time consultant to the Los Angeles County chief medical examiner and coroner's office; and I am the chief psychiatrist and codirector of the Suicide Prevention Center in Los Angeles.

From my experience I can testify to the tragedy of suicide, both for the primary victims who die and for the secondary victims who are the survivors.

And I also can testify to the increase in youth suicide, which will be the subject of a report which I will be giving to a symposium on youth suicide this weekend here in San Francisco.

In the 1960's, when I first became interested in this subject of suicide, youth suicide was considered to be rare. When Eli Robbins, in St. Louis, surveyed all the suicides in 1958—134 cases of suicide, the youngest person was a 24-year-old alcoholic male.

I surveyed all the suicides in Los Angeles in 1964. Out of almost 1,500 suicides then, 31, 2 percent were under age 20.

When I repeated that same survey 15 years later, the total number of suicides was down, only 1,150; but there were more than 100, almost 10 percent, under age 20.

We need to review our research in suicide, because things have changed since the 1960's. We are not clear at all why, for instance, in Los Angeles, and in California, the overall suicide rates have gone down; and we don't know at all why the youth suicide rates have gone up, although we do have many speculations.

Surely the causes are multiple. There are many causes joining together, and the remedies will have to be multiple and the causes for any individual suicide are multiple.

In my work with suicidal persons, I encounter regularly three problem areas. The first is the area of mental illness, especially depressive disorders.

And the second is substance abuse, especially alcoholism, but also drug abuse; and the third is a set of false psychological attitudes, especially the attitude that suicide doesn't happen, or isn't going to happen ever; or that nothing can be done about it anyway.

Now, concerning mental illnesses and substance abuse, the Government has had in the past effective programs in place, and these should be maintained and strengthened, and the connection between these areas and suicide need to be clarified and emphasized.

I have noticed currently some difficulty in securing access to hospital services. That is associated with rapidly changing patterns of health care financing, and I think will be remedied.

We do need additional legislation, in my opinion, to encourage education, especially in the schools, to keep students and faculty. The suicidal States are transient; their troubles can be overcome, and help is available when young people feel desperate and hopeless.

Mr. LANTOS. Thank you, Dr. Litman.

Dr. Jay Muccilli.

STATEMENT OF DR. JAY MUCCILLI, Ph.D., PSYCHOLOGIST, SAN JOSE, CA

Dr. MUCCILLI. I am Jay Muccilli, a psychologist in private practice in San Jose, CA, and have been counseling and dealing with children and adolescents for approximately 17 years, until this last year when I became a survivor victim. My 15-year-old nephew, who had transferred down from Tacoma with his family, was a gifted student, again, and who was not an outgoing, gregarious type

fellow, was having some trepidation about starting school at San Mateo, where his family had moved.

The family was not really integrated in the community, as the community chose to live somewhat isolated. Steven spent the weekend prior to his death with me, water skiing, at the suggestion of his mother, since he had been rather quiet and withdrawn for a couple of weeks.

By the time he came to spend the weekend with me, Steven was no longer withdrawn, and saying everything was fine, and seemed to be back to himself.

Two days after he returned to his family's home, he shot and killed himself, his third day of school. I guess since that time, which was September of 1983, I have become much more engrossed in the subject of child and adolescent suicide, and I have some ideas and feelings about it, both from my own personal experience, from interactions with Charlotte and some other individuals in the community, and my own research and reading.

First, I believe child and adolescent suicide is grossly unreported, probably for the same reason that childhood schizophrenia is grossly unreported; and that is, that it is an embarrassment to the family. If they can protect the family and so on, they do.

If you take a look at the fact that homicide has been replaced now by suicide as the second cause of death for children and that roughly 6,000 suicides, or supposedly 6,000 this year, and 23,000 accidents, I would venture to guess that if you looked at the underlying motivation of those accidents that approximately half of those will be suicidal type behavior.

I guess what I am saying is that I think suicide is probably the number one cause of death of teenagers or suicidal behavior.

I think what killed my nephew, and what killed my son's classmate at high school, was their inability to communicate what they were feeling, their feeling that it was not OK, selecting ears for counseling that were ill-equipped to handle what they had to say: namely, their peers.

I also believe as a clinician in a private setting, I will have very little impact on children's suicide on a preventive basis; and that really you are the only ones that have the forum to actually do something in prevention. This is unusual for me to say in the terms of the Federal Government. But I'm saying it.

The reason that I am saying this is that I feel teenagers rely on their peers. They will talk to their peers don't know how to deal with what is going on with them. Their teachers don't know how to deal with what is going on with them; and their counselors do not. We don't have a lot of counselors in our schools in San Jose. We are famous for being one of the few school districts that has gone bankrupt, I guess.

I went—I was asked to come to my son's school last spring, to give a talk on what it was like to be a psychologist to all the individuals in the individual society class.

One of the things we talked about was what type of people I see, and what kinds of things I do, and the subject of suicide came up; and I—I was unaware that a child that fall had killed himself because he had gotten poor grades, and his parents were away on vacation.

And rather than face them, he just decided to overdose. And I asked the students how they dealt with that story, and if they talked about it. They hadn't. I asked the teacher who was teaching individual psychology—individual society, and so on. They had not talked about it.

The faculty had not talked about it. Everybody was afraid to talk about it. It was the old myth: if we talk about it, we will precipitate more suicide; and this was after the Plano group of suicides in Plano, TX, and everybody was rather hesitant about doing this.

I asked them if the faculty of the school if they would be interested in a pilot project should that happen where they could be educated in terms of working with children, to deal with suicide and to help children to deal with other children; and they were. And the school, in fact, had volunteered.

I believe that you must do something at that level in terms of the educational process. I don't think you can do it individually in terms of clinicians. They don't come for help because that is admitting what they are fighting against. They are crazy. Something is wrong with them. They don't want to see something wrong with them.

And I think if you frame it in a school setting, one of the projects that Charlotte has done where you are helping the child, the children to become active listeners and then counsel and support, then you are not hitting them in their own ego, saying we ought to train you what to do when you are depressed. We want to train you how to help your friend to recognize when they are depressed; meanwhile, they can help themselves, like I have a friend who has this problem much of us have seen.

I don't feel that more research on the etiology and epidemiology of suicide is really to the best interest of a suicide prevention program. I think if you are going to divert resources to that, that may be of use for young children, which we still don't know about, and which I feel are even more reported.

But I think there are models for successful programs for adolescents that can deal with what is killing them, which is their inability to communicate about their feelings and to understand the depression and feelings that they are having.

And I guess that is about my message.

Mr. LANTOS. Thank you very much, Dr. Muccilli.

Next, we will hear from Mr. Patrick Arbore, who is the geriatric counselor and researcher at the San Francisco Suicide Prevention Center.

We are happy to have you, Mr. Arbore.

Mr. ARBORE. Thank you very much.

STATEMENT OF PATRICK ARBORE, GERIATRIC COORDINATOR, SAN FRANCISCO SUICIDE PREVENTION CENTER

Mr. ARBORE. I am also very happy to be here to speak on behalf of the depressed elders I work with, and to share some information about elderly suicide.

About a year ago this time, I saw a film on TV, and it was called "The Right Way."

And it distressed me as greatly as "Silence of the Heart" inspired me.

There wasn't much hoopla about it. It was the story of an elderly couple who choose suicide as a means to coping with some stressful situations.

But it left little hope for the elderly, and it was really distressing to me personally. Every year in the United States between 6,000 and 8,000 older adults choose suicide. Some geriatric authors go so far as to say about 10,000 older adults will kill themselves; and they also feel that these figures are uncertain since a lot of elderly suicides are passive, or what are called "equivalent suicides." These are people perhaps in nursing homes or people who have been suffering severe losses who choose to starve themselves, who mix their medications in such a way that they cause themselves harm, or they don't comply any longer with their drug regimen.

Some of the factors that create an atmosphere where an elder will choose suicide or talk about suicide include depression, and I am sure this is the same for youth also.

But I think depression in the older adult is a little different. One in six elder depressives succeed in committing suicide, compared to 1 in 100 in the general population.

And yet there is a stigma attached to working with the older client who is suffering from depression as if they are not going to respond as well as a younger person to treatment; and I think that is really false.

I think that the older client can respond as well, if treatment options are offered to them. Oftentimes they are not.

Physical illness coupled with the depression also adds to an at-risk elder. We are working currently with several elders who are in bad physical shape. One was diagnosed with cancer, and she had an operation; and she will talk to me and say, "Ever since I had this operation for the Big-C, I feel like I am going to kill myself. I just can't accept that. I can't deal with that factor."

And she has been depressed ever since, and yet when she talks to her physician about her feelings about suicide, the physician told her that she should do volunteer work, that that would take care of her problem.

And it is so distressing for her, and for me when she tells me that, that that was her option for taking care of this depression and the fear around suicide and cancer.

Isolation is another factor that is terribly important to be aware of, since half of the elderly suicides are committed by those people who live alone.

The program that I represent at San Francisco Suicide Prevention is called the Friendship Line for the Elderly.

In this program we work with older adults who are isolated, who are frail, who are trying to remain independent in a society that doesn't offer them much hope; and we try to lessen their isolation by providing volunteers who are trained in issues regarding depression.

We have about 45 volunteers from the ages of 21 to 85, and we encourage the older volunteer because they understand much more strongly some of the issues confronted by our participants who are isolated, and who have suffered major losses.

As I hear the other people giving testimony, talking about losses that have occurred to a young person, in our older adults—their losses accumulate also, and sometimes rather rapidly. In later years where they don't have the network to draw upon for support, it can become a really desperate time.

I recently supervised a study of elderly suicide in San Francisco from the years 1970 to 1980 inclusively; and there were 617 reported suicides of people 60-plus. These people killed themselves more often through the use of drugs and alcohol, but they also chose very violent methods, such things as hanging, jumping, shotgun wound to the mouth or to the head or to the brain; and also the ingestion of caustic substances such as Liquid Plumber, and also putting a bag over their head so that they would be sure that they would die.

Older adults tend not to survive their suicide attempts, so another factor that we look for is previous attempts. Insomnia, alcoholism—and all these things are very difficult in working with the older client, and it is difficult to get the support of the professionals in the community to try to help them through these very difficult times.

I think that one of the most important things that I am hoping will come out of this is more awareness about the plight of the older adult who is depressed, who is isolated, who is suffering the loss of their spouse, who is struggling with severe economic problems, who is being threatened out of the home where they have lived for 30 or 40 years, and threatened with institutionalization.

Our program is a very small program, and it can't continue without funds, and yet right now we are working with 150–200 clients that we contact and visit on a regular basis.

The suicide rate in San Francisco for the older adult has diminished, hopefully in part due to our program as well as other geriatric programs that are in existence in San Francisco.

Thank you very much.

[The prepared statement of Mr. Arbore follows:]

PREPARED STATEMENT OF PATRICK ARBORE, GERIATRIC COORDINATOR, SAN FRANCISCO SUICIDE PREVENTION, INC.

While adolescent suicide continues to be the focus of attention, suicide and the elderly would appear to be less of a concern. However, this is not true. Each year in the United States between 6,000 and 8,000 elders will commit suicide. Some geriatric authors suggest that 10,000 elders will take their own lives this year. Although the elderly comprise only 11 percent of our population, they account for 25 percent of all reported suicides. Startling as these statistics are, they may represent an underreporting of the true incidence. Elderly suicides may be undetected. Noncompliance to a drug regimen, refusal to eat and mixing medications are common ways in which an elder can slip silently into a non-reported suicide.

Traditionally the elderly have been confined to one massive group, i.e. those persons over the age of 60 or 65. Many researchers emphasize the need for a sub-division of this large elderly category. Distinctions are now being made among the young-old (60–70), the middle-old (70–80) and the old-old (80+). The old-old age group has been identified as the fastest growing segment of the older population of the United States. This population, however, is probably one of the least studied groups by social researchers since they do not lend themselves readily to traditional methods of investigation. When one considers that white males over the age of 75 have a suicide rate higher than any other age group, it is important to look at this at risk population.

In order to do this, however, certain biases will have to be overcome. Certain studies have shown that people of all ages feel that suicide is less objectionable in old

than younger ages. Does this bias uncover our culture's obsession with youth and devaluation of the aged?

What are some of the factors inherent in an elderly suicide?

DEPRESSION PHYSICAL ILLNESS, ISOLATION

Depression is more likely to lead to suicide in older than younger patients. In most elderly suicides the depression has lasted less than a year. It is urgent to intervene so that this one depression in later life isn't their last. That is, one in six of depressives succeed in committing suicide compared with one in 100 of the general population.

Since most depressions are remediable in the elderly, various treatment options should be offered in order to reduce the suicidal risk.

Physical illness is also an important factor in elderly suicides. In my own research of elderly suicides in San Francisco, suicide notes often referred to the physical pain the elder could no loner endure. All efforts should be taken to discover ways in which the elder can cope more effectively with their physical ailments in order to help diminish their depression.

Those elders who are physically unwell and depressed become particularly vulnerable if they are also isolated. Those elders who have become newly isolated through bereavement, divorce or bodily dysfuction may be particularly vulnerable. About half of the elderly suicides are comprised by this group who are living alone.

Additionally, prior suicide attempts and expressions of suicide intent are obvious indications of an at risk elder. Sadly, however, since most elders who attempt suicide succeed coupled with the inhibition to provide psychological help, these indicators cannot be relied upon.

On a local level, a study was undertaken to analyze those elders who committed suicide in San Francisco from 1970 to 1980.

The overall suicide rate among the San Francisco elderly decreased dramatically from 1970 to 1980, from a rate of 60.2 in 1970 to a rate of 32.6 in 1980. Nationally, this rate fell from 22.5 in 1970 to a rate of 17.8 in 1980.

It was found that between the years 1970 and 1980, inclusive, there were 617 suicides committed by persons over 60 years of age. Of these 617 elderly suicides, 23.5 percent were committed by the young-old, 37.28 percent were committed by the middle-old and 39.22 percent were committed by the old-old age group. The suicide rate for the 75 plus age group has consistently been almost twice that of the young-old or middle-old age groups.

In keeping with the literature on suicide, men accounted for 59.64 percent of all elderly suicides in our study. While suicide rates for men and women declined from 1970 to 1980, the reduction in rates is much greater for women. For men, however, the difference is much less—from a rate of 74.46 in 1970 to a rate of 59.24 in 1980, a difference of 15.22, less than half the figure for women.

Please refer to the attached tables which describe various other demographics obtained in this study.

The information obtained from our study suggest that the older (75+) unmarried white male who has easy access to medication may be the elder at greatest risk of suicide.

It is clear that suicide among the elderly is a problem in San Francisco, a problem that continues to exist but has not received much attention.

San Francisco Suicide Prevention attempts to deal with suicide and the elderly through its geriatric companionship program, the Friendship Line for the Elderly (FL). The FL, begun in 1973, is a 24-hour telephone service providing information and referral, crisis intervention, emotional support to any the 138,000+ elders who reside in the City and County of San Francisco. Through the companionship program trained volunteers make regular telephone calls to frail, depressed, suicidal and often homebound elders to offer emotional support and counseling. Friendly visits also are maintained on a frequent basis.

Through the FL program elders are helped to remain independent for as long as they are able. Since losses accumulate at a rapid rate in older years, FL volunteers are trained to help the elder cope with the losses. Should an elder be forced into an institutionalized setting either on a temporary or permanent basis, the FL volunteer continues their ongoing support to help lessen the sometimes devastating impact of transfer trauma.

The FL is the only program in San Francisco that confronts the issue of suicide in the older adult. We are concerned about the loneliness and losses that beseige the elders in our community. Through FL volunteers, our elders have an opportunity to share their feelings with sensitive, caring others. Since our volunteers range in age

from 21 through 85, many talented older adults can contribute to their community through giving to their less fortunate peers through our program.

Practitioner serving the elderly must concentrate not only on individual problems but they must also look at these problems in the context of a much broader sphere, i.e., the social conditions under which the elderly are forced to live. Agencies serving the elderly must understand the distribution of services to the elderly, so that they can act to assure the continued availability and deliverance of those services to our needy seniors. We must not allow our agencies and clients to fall victim to conservativism in the allocation of funds for seniors.

The time is ripe for practitioners, clients, politicians and the general public to come together to save human services. It is through political, action that the day-to-day lives of our elders will improve, and we won't then have to ask the question, "Why can't they cope?" We will have already answered the question, "How can we make society more responsive to the needs of its elderly?"

TABLE I—AGE AND SUICIDE IN SAN FRANCISCO 1970 TO 1980

A. TOTAL NUMBERS OF SUICIDES BY YEAR

Year	60–64	65–69	70–74	75–79	80–84	85–89	90–94	94–100	100+	Total
1970	18	18	13	9	15	4	3	0	0	80
1971	17	17	12	9	11	3	0	0	0	69
1972	11	11	8	13	9	5	0	0	0	57
1973	17	13	9	9	2	3	1	0	0	54
1974	17	12	10	12	2	3	0	0	0	56
1975	9	8	6	9	8	6	1	0	0	47
1976	13	7	8	8	12	1	1	1	0	51
1977	12	10	11	12	9	3	0	0	0	57
1978	10	12	13	7	7	2	0	1	0	52
1979	11	8	10	9	9	3	1	0	0	51
1980	10	6	8	4	10	4	1	0	0	43
X	13.18	11.09	9.82	9.18	8.55	3.36	.72	.18	0	617
Percents of total	23.50	19.77	17.50	16.37	15.24	6.00	1.30	.32	0	100

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B. SUICIDE RATES PER 100,000 POPULATION IN SAN FRANCISCO

Year	60–64	65–74	75 plus
1970	43.40	49.64	83.12
1980	29.94	23.06	43.58

TABLE II—SEX AND SUICIDES IN SAN FRANCISO 1970 TO 1980

A. TOTAL NUMBER OF SUICIDES BY SEX

Year	Female	Male	Total
1970	43	37	80
1971	29	40	69
1972	30	27	57
1973	21	22	54
1974	24	32	56
1975	17	30	47
1976	15	36	51
1978	17	35	52
1979	20	31	51
1980	11	32	43
Total	249	368	617
Percent of total	40.36	59.64	
X	22.64	33.45	

B. RATES BY SEX AND YEAR

Year	Female	Male	Combined
1970	53.34	74.46	62.16
1971	34.36	82.92	52.41
1972	45.29	49.87	47.17
1973	29.46	49.87	37.83
1974	29.20	54.50	39.59
1975	22.26	61.88	37.44
1976	18.58	65.53	44.82
1977	33.11	58.96	43.77
1978	28.00	63.67	40.73
1979	27.82	56.07	38.49
1980	14.02	59.24	33.08

TABLE III—ETHNIC BACKGROUND AND SUICIDE IN SAN FRANCISCO'S ELDERLY

A. TOTAL NUMBER OF SUICIDES BY ETHNICITY

Year	Black	Chinese	Hispanic	White	Japanese	Filipino	Natural American	Other	Total
1970	2	2	1	70	1	2	0	1	80
1971	0	0	1	68	0	0	0	0	69
1972	1	1	1	54	0	0	0	0	57
1973	4	1	0	49	0	0	0	0	54
1974	4	4	0	47	0	1	0	0	56
1975	0	3	0	43	1	0	0	0	47
1976	0	2	0	49	0	0	0	0	51
1977	2	2	0	52	0	1	0	0	57
1978	0	1	2	49	0	0	0	0	52
1979	2	3	0	46	0	0	0	0	51
1980	1	3	3	36	0	0	0	0	43
Total	16	23	8	563	2	4	0	1	617
X	1.45	2.09	.73	51.18	.18	.36	0	.09	
Percent	2.59	3.73	1.30	91.25	.32	.65	0	.16	

B. WHITE AND NONWHITE SUICIDE RATES OF 65+ POPULATION

Year	Nonwhite	White
1970	62.44	70.18
1971	7.35	68.54
1972	21.42	55.38
1973	20.83	50.10
1974	34.24	47.71
1975	20.68	43.52
1976	13.24	48.80
1977	24.24	50.58
1978	6.02	47.52
1979	23.95	44.27
1980	19.06	36.26

TABLE IV.—MARITAL STATUS AND SUICIDE IN SAN FRANCISCO'S ELDERLY

A. TOTAL NUMBER OF SUICIDES BY MARITAL STATUS AND YEAR

Year	Never married	Married	Widowed	Divorced	Separated	Unknown	Total
1970	7	25	29	8	0	11	80
1971	10	23	20	5	1	10	69
1972	5	22	20	7	0	3	57
1973	10	21	11	6	0	6	54
1974	5	17	15	11	1	7	56
1975	3	14	15	2	1	12	47
1976	7	12	12	7	0	12	51
1977	2	18	17	4	1	15	57
1978	10	11	13	5	0	13	52
1979	3	10	14	3	0	21	51
1980	2	16	4	4	0	17	43
Total	64	189	171	62	4	127	617
X	5.82	17.18	15.55	5.66	.36	11.55	
Percent	10.37	30.63	27.71	10.05	.64	20.58	99.98

B. SUICIDES BY MARITAL STATUS FOR SAN FRANCISCO'S POPULATION IN GENERAL, 1971–1977

Marital status	Total suicide		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Not Married	750	45.6	354	52.2	196	33.6
Married	429	26.1	274	25.8	155	26.5
Widowed	135	8.2	45	4.2	90	15.4
Divorced	273	16.2	147	13.8	126	21.6
Separated	44	2.7	30	2.8	14	2.4
Unknown	15	.9	12	1.1	3	.5

TABLE V.—METHOD OF SUICIDE AND ELDERLY IN SAN FRANCISCO

A. TOTAL NUMBER OF SUICIDES BY METHOD AND YEAR

Year	Hanging	Suffocation	Gunshot	Jumping	Drowning	Pills	Alcohol	Caustics	Burns	Carbon dioxide	Misc.	Total
1970	12	1	7	19	2	36	0	1	1	1	0	80
1971	8	8	10	9	3	27	1	1	0	2	0	69
1972	2	2	15	11	1	25	0	0	0	1	0	57
1973	2	2	10	13	0	18	5	0	1	3	0	54
1974	6	3	15	5	3	17	1	3	2	1	0	56
1975	1	4	10	8	3	20	1	0	0	0	0	47
1976	5	5	16	6	3	14	1	0	0	1	0	51
1977	3	2	15	12	3	16	0	3	0	1	2	57
1978	1	2	17	11	1	16	2	1	1	0	0	52
1979	5	3	10	9	0	19	4	0	0	1	0	51
1980	7	0	13	8	2	12	1	0	0	0	0	43
Total	52	32	138	110	21	220	16	9	5	11	2	617
X	4.72	2.90	12.55	10.0	1.91	20	1.45	.82	.45	1.0	.18	
Percent	8.43	5.17	22.37	17.83	3.40	35.66	2.59	1.45	.81	1.78	.32	99.81

TABLE VI. METHOD OF SUICIDE BY SEX AS A PERCENTAGE OF TOTAL SUICIDES, SAN FRANCISCO, 1971-77 AND UNITED STATES, 1976-78

METHOD OF SUICIDE

	Total percent		Male percent		Female percent	
	San Francisco	United States	San Francisco	United States	San Francisco	United States
Poisoning by solid or liquid substance	36.7	13.4	29.2	7.2	50.0	30.5
Poisoning by gas	3.3	9.2	4.2	8.5	1.5	11.0
Hanging or suffocation	10.2	13.3	11.4	14.1	8.0	11.2
Drowning	1.5	2.0	1.3	1.4	2.0	3.5
Firearms	21.9	55.8	28.0	63.0	11.0	35.9
Cutting and piercing instruments	1.6	1.5	2.2	1.5	.7	1.4
Jumping from Golden Gate Bridge	8.7		7.3		11.5	
Other jumping from high places	13.4	3.1	13.6	2.7	13.0	4.4
Other and unspecified means	2.6	1.8	2.7	1.6	2.1	2.1
Total	99.9	100.1	99.8	100.0	99.8	100.0

Sources: Office of the San Francisco Coroner; Mortality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, "Vital Statistics of the United States, Vol. II., Mortality."

SAN FRANCISCO SUICIDE PREVENTION, INC.—1982

FRIENDSHIP LINE FOR THE ELDERLY—752-3778

The Friendship Line program is a 24-hour telephone service for all senior citizens of San Francisco as well as a means to connect with a high risk population—the frail, isolated and often homebound elder.

Twenty-five percent of all reported suicides are committed by the elderly. The elderly person who is living alone, in ill health, depressed and lonely is someone who is considered to be at high risk of suicide. One of the goals of the friendship line is to reduce the numbers of elderly suicides through lessening the loneliness of this group of people. This goal is sought through two methods:

(1) Where possible, an isolated elder is linked to a trained volunteer through regularly scheduled telephone contacts;

(2) A friendly visit is arranged and regularly maintained when appropriate.

Isolated elders are referred to us in several ways including:

(1) An elder calls in on the Friendship Line or crisis line and the volunteer discovers that the caller is homebound, depressed, in crisis, etc. and a follow-up call is made to evaluate the appropriateness of the Friendship Line program for this person;

(2) A social worker, nurse, physician or other health care professional refers an elder to us for a variety of reasons;

(3) A concerned family member refers their aged parent or relative to us.

Friendship Line volunteers currently range in age from twenty to eighty-four. Many of these volunteers have participated in the eight week suicide prevention training program. However, an ever increasing number of volunteers are interested exclusively in our geriatric program. Thus, these volunteers receive geriatric training only. Ongoing training classes are offered throughout the year as well as case conferencing meetings wherein the volunteers have an opportunity to discuss the concerns and rewards of their work with staff and other volunteers.

The minimum commitment expected of a Friendship Line volunteer is to maintain weekly telephone contact with at least one isolated elder. One friendly visit per month is strongly encouraged but not mandatory at this time. Submitting progress notes of all contacts with friendship line paticipants is required so that the geriatric coordinator can be kept aware of the work which is being done.

For information about our Friendship Line for the Elderly, call 752-3778. This service is made possible, in part, from funds received through the Commission on the Aging.

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Mr. LANTOS. Thank you very much, Mr. Arbore.

Ms. Perlman, you will be presenting testimony for Dr. Berman who is president of the American Association of Suicidology.

Ms. PERLMAN. I would like to correct that. I am the executive officer of the association, and I will be speaking on behalf of the association. OK.

Mr. LANTOS. Very good.

Ms. PERLMAN. OK.

Mr. LANTOS. We are very happy to have you.

Ms. PERLMAN. Thank you very much for asking me to testify.

STATEMENT OF JULIE PERLMAN, EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF SUICIDOLOGY, WASHINGTON, DC

Ms. PERLMAN. I would like to first let you know exactly what the association does and is. We have been in existence for approximately 18 years. We provide resources not only to our members but to anyone in the United States who has an interest in suicide prevention.

We provide resources such as pamphlets, statistics. We have an annual conference once a year, where people who have done research get together; clinicians get together. We provide a forum for anyone who is doing work in the field of suicide prevention to present their findings.

We have a directory of suicide prevention centers. And for the public at large we provide—we act as a clearinghouse for information on suicide.

I would like to tell you how I have seen through the headquarters of the association, how I have seen this increase in youth suicide. What I have seen in the last few years is a tremendous increase of persons writing, calling our office, and saying we are having this problem in our community, and we don't know what to do; and can you tell us where to go, and where to get help.

And what I have done is to refer them to all the places that I know are in existence, and they have grown tremendously, first of all, as Charlotte's program, if they want a school program, as well as some of the others.

I have compiled the list of all the suicide prevention programs in schools that I know of, and I provide this to anyone who calls.

But it isn't enough; we need some sort of a national model for programs so that any school system or community could adapt. We need the money for this. There is not enough money for this. We need research in youth suicide. Not enough is being done now. There just isn't the money.

We need a public awareness campaign, national campaigns, so that everyone can learn how to spot the clues of a suicidal person, how to help because suicide prevention is everybody's business. It

isn't just the professional's business. Anyone can learn how to help a suicidal person.

So, the association is very committed to this bill, and to the National Commission, and we offer our services in any way we can.

Mr. LANTOS. All right, thank you, and I am very grateful to you, and want to commend you for the work of your organization.

The final member of this panel is Melissa Kohn, who works as a volunteer in a crisis center and has had personal experience with a friend who was a suicide victim.

We are happy to have you.

STATEMENT OF MELISSA KOHN, STUDENT AT THE UNIVERSITY OF CALIFORNIA; FRIEND OF SUICIDE VICTIM; VOLUNTEER IN CRISIS CENTER.

Ms. KOHN. My name is Melissa Kohn, and I am currently a student at the University of California in Berkeley. However, I became involved with suicide prevention when I had the opportunity to attend one of these programs we speak about as suicide prevention program.

But I really believe I became involved even longer than that, when my friend Marvin decided to take his life. At age 16, he drove his car off a cliff. First, everyone believed it was just an accident, because that is what everyone wanted to believe. Marvin was a wonderful person; everyone loved him. Everyone loved Marvin, and it was just easier to accept that it was an accident. But they looked into it further, and as they did there was no way that they could not admit it. It was a suicide, and it was very tragic.

Marvin's death affected everyone. It affected the students; it affected me; it affected his family, and it affected his friends. One of his friends, I would say, probably has never recovered. He was at the time was to go away to school, and was not even able to leave for school at the time.

So, it really had an effect on a lot of people's lives, and it is very tragic. I am thinking now, after attending and being involved with the suicide prevention and volunteering at the crisis center, and things of that nature that, with the knowledge I have now, maybe I couldn't have prevented it, but I think I definitely could have helped in some manner. And yes, maybe it could have been some source of prevention. He definitely had a lot of the symptoms that are now known as definite, you know, clues into suicides, such as he was always joking around. He was never serious; even when it was a serious matter, he was never serious.

He started giving away articles of his clothing, which was quite unusual; and he constantly talked about killing himself, but in a joking manner that no one ever took him seriously, because you just didn't think that Marvin would take his life. Well, he did. And like I say, it was very tragic.

Even more so, though, in the past 2 weeks alone, I have talked to two people who have shared this same experience—two friends who have committed suicide; two kids in college—people just like me. White children—and we are not talking about the run-of-the-mill kid that you would think you would find as a suicide victim. These

were bright kids; they were at college. It is not like they didn't have knowledge of this.

I'm just here to tell you today that pressures like everyone has said before, on youth, are tremendous. We are supposed to get good grades; we are supposed to be the most popular; we are supposed to be successful; we are supposed to be the best in everything we do; and it is a tremendous responsibility. I am sure everyone is well aware of that.

But at the same time often it seems unbearable, while at other times it is exciting. Sometimes, you just think you can't live another day.

And I know I am concerned with it, and I think that the fact that the Daily Cal, a school that I attended, our newspaper, in fact, just a couple of weeks ago had an article on suicide. So, it shows that we are really concerned, and we really want the chance to do something.

I am here today to make sure that all my peers have the same opportunity I do, to live life to the fullest, and I really believe that the suicide prevention method— if they would talk to the peers, if we had the knowledge, if people were made aware of the clues, indications into suicide, that we could have an effect, because naturally, like it's been stated before, no, you don't necessarily go to your parents; it is hard to talk to your parents. You don't want to make them upset.

You don't go to your teachers; you don't go to your counselors. I know when I was in high school, the last person I would have gone to would have been a teacher or a counselor.

I think more so it would be your friends, the people you spend a great amount of time with that could actually have some impact and could actually possibly prevent the suicide.

So, I can say today, I am here to represent the youth, and to say that we are concerned, and that we would like to do something about it.

Mr. LANTOS. Thank you, very much.

There is one question that I would like to ask of as many of you as you would care to respond.

Dr. Muccilli, you suggested in your view, which I take it, is fairly generally shared, suicide is dramatically underreported.

Is this the view of the others on the panel, too?

Ms. Ross.

Ms. Ross. I think we are getting increasing evidence as to just how underreported it is, but I am sure that Dr. Litman can also address this. I think Dr. Muccilli may have been conservative. We used to estimate that the actual number of suicides across the ages were four times the reported number. I think it is higher among the youth.

I think the recent studies—there are many surveys going on across the country now, asking people, and certainly the young how often they had attempted suicide, because we really have to look at two things. We have to look at the people we lose through suicide, and we have to look at suicidal behavior, the attempts, which are just—are like that, a warning of what is coming.

When our later studies show us that a little over 2 million high school youngsters will make a suicide attempt in 1984, I think that attests to the parameters of the problem.

He may want to add to that.

Mr. LANTOS. Dr. Litman.

Dr. LITMAN. I have studied the way that coroners and medical examiners or chiefs of police, the certifying authorities in various communities go about establishing for the record a death certificate, whether it should be recorded as natural or accident or suicide, or homicide. And, of course, the standards vary greatly.

I remember for many years a large city, Honolulu, had a very low suicide rate, and we would all speculate about it, and—until I talked with the chief of police who was the certifying authority. And he said flatly that he would not certify a case of suicide unless he found a note, and even then he would check the handwriting to make sure that it was in the person's own handwriting.

Since in Los Angeles and in other communities, one finds a note in about 30 percent of the cases when one looks very hard for it, you can see that by that criterion a city would have a low suicide rate.

It is true in many smaller towns, and even in large communities, the family puts a great deal of pressure on the certifying authority to try to have a death certificate that does not say "suicide."

So, even in my own office where we consult with the coroner and do what we call "psychological autopsies," our reconstructions of the person's—dead person's life, lifestyle, last events, talking to many people about that person—even when we make a very concerted effort to have accurate death certificates, I know that many cases that slip by, are certified as natural by the doctor and never get to the coroner. Only 1 death in 5 gets to the coroner. Or it is concealed in other ways.

So, I have always thought that this out-and-out suicide, which we would all agree, probably is about half again as large as is reported, and then there is this whole area of suicidal behaviors where people contribute to their own deaths, which we, for instance, which we—by convention we call, let's say, a natural accident, a natural death, when someone who is an alcoholic and has been warned that it would be fatal to continue drinking, and they go ahead and continue drinking.

We don't call that suicide, but certainly that is close to it. And many other types of deaths, which, for one reason or the other, we don't call suicide.

So, it's generally underreported, the cause of death.

Mr. LANTOS. From the point of view of the layman who hasn't done work in this field, there seems to be an enormous difference between the phenomenon of teenage suicide and the phenomenon of elderly suicide.

Is that a legitimate distinction from a clinical point of view, Dr. Litman?

Dr. LITMAN. Every individual—there are so many circumstances and attitudes and life events that contribute to making a person suicidal—all sorts of different things.

Probably there are different connections more common for older people. For example: for older people health problems are quite im-

portant, and loneliness problems that have been mentioned. Whereas, for younger people health problems are not so prominent—and it is different at each age range. For very young children, under puberty, under 12, let's say, often the problems are connected with a death in the family, an identification with a dead person, feelings rejected; and we have found, often are found with mental or brain damage, difficulties in acquiring language, and school problems.

In the age range of 13—adolescence, 13 to 18, a dominant problem often is learning to leave home and developing a peer network.

And then 25—the 19 to 24, the young adult, love problems predominate as a triggering mechanism. And so on. Later on in life, often family problems and adjustment problems. And finally, into the elderly, where there so often is a loss of key people in one's life to death, and in a general a need to adjust to a downward course in one's life and in health and attachments.

Mr. LANTOS. Is there any member of the panel who would like to make a final observation before we ask the members of the final panel to take their places? Yes, Ms. Ross.

Ms. ROSS. I am just going to make one comment. You have asked a number of questions trying to understand the suicidal person, and we have talked about the young and the old.

And I think—I just want to end with one comment, and that would be to try to give you a picture other than the statistics of the sound of despair of one person, and I wanted to read a note left. This person did not suicide. But this was a note expressing that point in which he was making the choice.

And this was neither someone who is very young or old. Middle aged person, young adult by my age standard.

I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on Earth. Whether I shall ever be better I cannot tell. I awfully forebode I shall not. To remain as I am is quite impossible. I must die to be better it appears to me. I can write no more.

This was just to illustrate or try to give you a feel for despair that people feel, and we have heard that they can be outgoing or not outgoing, bright or not. This note was written by Abraham Lincoln. And I just wanted you to get a picture that it can happen in any family and in any profession, any occupation.

And we all do need to get together. It is in our families and yours. And with your help, we will do something about it. Thank you.

Mr. LANTOS. I am very grateful to all of you, and your testimony will be part of the committee's permanent record.

We hope your time allows you to stay and listen to the last panel, which I would now ask to come forward. Dr. Persida Drakulich representing Superintendent of Schools Bill Honig. Ms. Jean Forstner representing U.S. Senator Alan Cranston. Dr. Catherine Smallwood, director of the Cindy Smallwood Foundation. Everell Mitchell, director of pupil personnel and guidance at the Oakland Public Schools. I am very happy to have all of you with us. Dr. Drakulich, we are ready to take your testimony.

STATEMENT OF DR. PERSIDA DRAKULICH, Ph.D, REPRESENTING STATE SUPERINTENDENT OF SCHOOLS BILL HONIG AND THE CALIFORNIA STATE DEPARTMENT OF EDUCATION

Dr. DRAKULICH. Thank you very much. Youth suicide is an emotional topic, and this is undeniable. Many of us wish we did not have to address the topic, and this is understandable, but the need is there. The statistics you heard today can tell us. To meet this need, the California State Department of Education, school health in the school climate unit is now engaged in a planning and development of the statewide youth suicide prevention program in the schools, in cooperation with the county offices of education and suicide prevention centers in San Mateo and Los Angeles Counties. This program is meeting the intent of the legislature who finds and declares that it is of vital importance that a statewide primary prevention program be established with shared responsibility at both State and county levels, and that this cooperation shall be a major tool in efforts to achieve the successful prevention of youth suicide.

Education code section 10200, enacted by the Senate bill 947, Senator Presley, 1983, states that a statewide youth suicide prevention program is essential in order to address the continuing problem of youth suicide throughout the State. This program must emphasize a partnership between educational programs at the State and local levels and community suicide prevention and crisis center agencies.

The department supports the need for a youth suicide prevention program. The department has had an appointed member on the State senate advisory committee on youth suicide prevention since August of 1982. Superintendent Bill Honig has publicly endorsed this program in a televised press conference.

The department's objective is to plan and develop a comprehensive statewide youth suicide program by June 1985. The demonstration programs will be operated in cooperation with two established community suicide prevention centers through interagency agreements with the Los Angeles and San Mateo County offices of education. Other counties will be invited to participate in a statewide planning and development according to procedures published by the department. The program content will consist of classroom instruction, community based programs, parent education, and teacher training.

The Governor's budget for education allocates $315,000 for this program, $300,000 for local assistance, and $15,000 designated for department operations.

The school climate unit and the school health unit within the department of education are currently assisting suicide prevention centers in developing a classroom curriculum in the following areas. Decisionmaking, ethical development, the awareness of the relationship between drug and alcohol abuse and youth suicide, recognition of suicidal tendencies and other facts, information on available community, youth suicide prevention services, and enhancing the total school climate including relationships between teachers, counselors and pupils.

The second component is the nonclassroom community based alternative programs, peer group programs, 24-hour hotline services,

data collection on attempts of suicide, intervention-prevention services, parent education programs and training.

Teacher training is the third and very important component of this total program. These demonstration programs will be offered through interagency agreements with county boards, and statewide workshops will be conducted for school and community personnel to review the content and training strategies.

The State department of education under Mr. Honig's direction will administer this program and submit an annual report to the legislature and to our government on the current status and program effectiveness. The programs will operate for 3 years maximum beginning July 1, 1984 to June 30, 1987. Each county shall evaluate its demonstration program and submit a report to the department of education, the legislature and the Governor by January 1, 1987. This innovative program which is mandated by the State legislature offers great promise in addressing this mounting problem.

I wish to quote from the CBS Television teachers' guide on "Silence of the Heart".

> Young people know about suicide. It may have occurred in their families and among peers. They most certainly hear news of it. Young people get indirect messages from many around them that talking about depression or suicide is not appropriate. This can create barriers and prevent the possibility of getting help.
>
> Youngsters get depressed, and often don't even know that what they feel has a name, much less that others sometimes feel as they do and that help can be found.
>
> When depressed, we all need someone to listen to us. A problem shared is a problem halved.
>
> Sometimes being open isn't enough. Professional help is needed and it is available. Many communities have suicide prevention crisis centers or hotlines. All communities have local or regional mental health associations.

This State mandated comprehensive programs offers assistance and service to all, the schools, the communities, parents, and most importantly, to the students themselves. The California State Department of Education has taken pioneering steps to initiate this program and this clearly would not have happened had not State Superintendent Bill Honig been willing to take these positive steps. The California PTA and California Teachers Assocation support his efforts and those of Senator Presley. This State program may serve as a model for California and the rest of the country. It is the Federal Government's role to assist other States, and we are sincerely eager to assist you.

I want to thank you for inviting me to represent my superintendent and to share what I think is one of the most needed programs mandated by our State legislature. Thank you.

[Material submitted by Dr. Drakulich follows:]

STATE OF CALIFORNIA, SENATE BILL No. 947

CHAPTER 750

An act to add and repeal Chapter 3 (commencing with Section 10200) of Part 7 of the Education Code, relating to schools, and making an appropriation therefore.

[Approved by Governor September 12, 1983 filed with Secretary of State September 13, 1983]

LEGISLATIVE COUNSEL'S DIGEST

SB. 947, Presley Schools: youth suicide prevention school programs.

Current law authorizes various programs to be jointly conducted by state and local educational agencies or institutions.

This bill would provide for the development of a statewide youth suicide prevention progam through the establishment of state-mandated demonstration programs in 2 designated counties. Existing suicide prevention and crisis centers located within those counties would serve as coordinating centers for the planning and development of the statewide program. Any interested county which submits a request to the State Department of Education to participate in that process by a specified date would be permitted to do so.

The bill would require the Department of Education to annually report to the Legislature regarding the status and effectiveness of the programs established pursuant to this act, and would establish a continuously appropriated Youth Suicide Prevention school Program Fund to be administered by the department for the purposes of this act. The bill would express the intent of the Legislature that $300,000 be appropriated to this fund by the Budget Act of 1984, and in the event that a lesser amount or no money is appropriated, that the youth Suicide Prevention School Program only be implemented to the extend funds are made available. The bill would specify that none of the provisions of this act shall be construed to prohibit the department from providing financial assistance from that fund to other counties, in addition to the counties maintaining the demonstration programs, for purposes of youth suicide prevention school programs. Any county receiving such funds would be required to annually provide the Director of Finance, the Legislature, and the department with a specified accounting and program evaluation report for the previous year.

The provisions of this bill would become operative on July 1, 1984.

Article XIII B of the California Constitution and Sections 2231 and 2234 of the Revenue and Taxation Code require the state to reimburse local agencies and school districts for certain costs mandated by the state. Other provisions require the Department of Finance to review statutes disclaiming these costs and provide, in certain cases, for making claims to the State Board of Control for reimbursement.

This bill would impose a state mandated local program in the two counties designated to maintain the demonstration youth suicide prevention school programs pursuant to the provisions of the bill.

This bill would provide that no appropriation is made by this act for the purpose of making reimbursement pursuant to the constitutional mandate or Section 2231 or 2234, but would recognize that local agencies and school districts may pursue their other available remedies to seek reimbursement for these costs.

This bill would repeal the provisions establishing the youth suicide prevention school programs on June 30, 1987.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Chapter 3 (commencing with Section 10200) is added to Part 7 of the Education Code, to read:

CHAPTER 3. YOUTH SUICIDE PREVENTION SCHOOL PROGRAM

10200. The Legislature makes the following findings and declarations of intent:

(a) A statewide youth suicide prevention program is essential in order to address the continuing problem of youth suicide throughout the state.

(b) The suicide problem often exists in combination with other problems, such as drug abuse and alcohol use.

(c) A suicide prevention program for young people must emphasize a partnership between educational programs at the state and local levels and community suicide prevention and crisis center agencies. In order to facilitate this partnership, the Legislature finds and declares that it is of vital importance that a statewide primary prevention program be established with shared responsibility at both the state and county levels, and that this cooperation shall be a major tool in efforts to achieve the successful prevention of youth suicide.

(d) The program established pursuant to this chapter is intended by the Legislature to delegate primary responsibility for the development of a youth suicide prevention program to existing county suicide prevention agencies through the establishment of a demonstration program. The Legislature recognizes that county suicide prevention and crisis center agencies are best suited for dealing with youth suicide, as demonstrated by their past success in youth suicide prevention in California.

10205. (a) in view of the purpose and intent of this chapter, as expressed in Section 10200, highest priority for program funding under this chapter shall be desig-

nated to those counties which emphasize joint school community youth suicide prevention programs.

(b) It is the intent of the Legislature that, to the maximum extent possible, funds made available for the propose of this chapter shall be used to support existing programs which have demonstrated a capacity to meet the needs of young people and families in the prevention of suicide, and to support two demonstration youth suidide prevention school programs, one of which shall be located in a Northern California county, the other in a Southern California county.

(c) In view of the urgent need to begin development of a statewide youth suicide prevention program at the lowest cost to the state, and with the participation of existing suicide prevention and crisis center agencies to the greatest extent possible, and in order to ensure that the program will meet the needs of all economic and ethnic groups in California, the Legislature hereby designates San Malco County and Los Angeles County as the locations of the two demonstration youth suicide prevention school programs.

10210. (a) The demonstration programs in San Malco and Los Angeles counties, hereinafter referred to as "demonstation counties," shall be maintained for a period not to exceed three years from the operative date of this chapter, according to the following schedule:

(1) Planning and development of the county demonstration program shall be completed by June 30, 1985.

(2) Implementation of the county demonstration program shall be completed by June 30, 1986.

(3) Each demonstration county shall evaluate its demonstration program and submit a report of its fundings to the State Department of Education, the Legislature, and the Governor on or before January 1, 1987.

10212. (a) Until October 1, 1984, any county in the state may, through its board of education, submit a request to participate in the planning and development of the statewide program to the State Department of Education.

(b) Each demonstration county shall designate the suicide prevention and crisis centers located within the county to serve as coordinating centers for the planning and development of the statewide youth suicide prevention school program. The State Department of Education, in cooperation with the designated coordinating centers, shall publish procedures for the participation of all interested counties in the planning and development of the statewide program.

(c) Planning and development of the statewide program shall be completed by June 30, 1985.

10213. No provision of this chapter shall be construed to prohibit the State Department of Education from providing financial assistance from the Youth Suicide Prevention School Program Fund to other counties, in addition to the demonstration counties, for purposes of youth suicide prevention school programs, including, but not limited to, those programs set forth in Section 10215.

10214. Funds received by a county board of education in order to carry out the purposes of this chapter shall be deposited in a separate county Youth Suicide Prevention School Program Fund established for that purpose. On or before January 1 of each year, any county which has received state funds for the purposes of this chapter shall provide the director of Finance, the Legislature, and the State Department of Education with an accounting of expenditures for its youth suicide prevention school program and revenues received for the program from sources other than the state, and with a program evaluation report for the previous year.

10215. The youth suicide prevention school programs established pursuant to Section 10210 shall plan, fund, and implement educational programs, which may include any of the following:

(a) Classroom instruction designed to achieve any of the following objectives:

(1) Encourage sound decision making and promote ethical development.

(2) Increase pupils' awareness of the relationship between drug and alcohol use and youth suicide.

(3) Teach pupils to recognize signs of suicidal tendencies, and other facts about youth suicide.

(4) Inform pupils of available community youth suicide prevention services.

(5) Enhance school climate and relationships between teachers, counselors, and pupils.

(6) Further cooperative efforts of school personnel and community youth suicide prevention program personnel

(b) Nonclassroom school or community based alternative programs, including, but not limited to:

(1) Positive peer group programs.

(2) A 24 hour "hotline" telephone service, staffed by trained professional counselors.

(3) Programs to collect data on youth suicide attempts.

(4) Intervention and postvention services.

(5) Parent education and training programs.

(c) Teacher training programs.

10220. The Department of Education shall enter into an interagency agreement with the approprite county board of education for the implementation of an approved Youth Suicide Prevention School Program.

10230. The Department of Education, the county board of education, school districts, and the county suicide prevention agency in each county maintaining a program pursuant to this chapter shall establish procedures for the coopetative collection and dissemination of data regarding the implementation of the provisions of this chapter.

10235. The Department of Education shall submit an annual report to the Legislature regarding the current status and effectiveness of the programs established pursuant to this chapter.

10240. There is hereby created in the State Treasury a fund which shall be known as the Youth Suicide Prevention School Program Fund. The fund shall consist of funds appropriated by the annual Budget Act, as well as any private sector money as may be made available. Notwithstanding Section 13340 of the Government Code, the fund shall be continously appropriated. The Department of Education shall administer the fund for the purposes of this chapter, and shall use no more than 5 percent of the balance of the fund to meet administrative costs.

10242. The provisions of this chapter shall become operative on July 1, 1984.

10245. This chapter shall remain in effect only until June 30, 1987, and as of that date is repealed unless a later enacted statute which is chaptered before June 30, 1987, deletes or extends that date.

SEC. 2. It is the intent of the Legislature that the sum of three hundred thousand dollars ($300,000) be appropriated from the General Fund to the Youth Suicide Prevention School Program Fund by the 1984-85 Budget Act. In the event that a lesser amount or no money is appropriated, it is the intent of the Legislature that the Youth Suicide Prevention School Program be implemented only to the extent that funds are made available.

SEC. 25. It is the intent of the Legislature that the Department of Education use a part of the amount appropriated from the General Fund to the Youth Suicide Prevention School Program Fund by the 1984-85 Budget Act for the purpose of complying with Section 10235 of the Education Code. It is also the intent of the legislature that the costs of complying with Section 10235 of the Education Code not be included in calculating the 5-percent limitation on expenditures for administrative costs imposed by Section 10240 of the Education Code.

SEC. 3. Notwithstanding Section 6 of Article XIII B of the California Constitution and Section 2231 or 2234 of the Revenue and Taxation Code, no appropriation is made by this act for the purpose of making reimbursement pursuant to those sections. It is recognized however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Chapter 3 (commencing with Section 2201) of Part 4 of Division 1 of that code.

Mr. LANTOS. Thank you very much, Dr. Drakulich. We appreciate your testimony. We will now hear from Ms. Jean Forstner representing Senator Cranston.

STATEMENT OF JEAN FORSTNER, REPRESENTING SENATOR ALAN CRANSTON, A MEMBER OF CONGRESS FROM THE STATE OF CALIFORNIA

Ms. FORSTNER. Thank you. I would like to read the Senator's statement to the committee:

Mr. Chairman, and members of the House Committee on Aging. I would like to thank this Committee for holding hearings today in San Francisco on the subject of teenage suicide. Although I cannot be here today with you in person, I am pleased to have this opportunity to share with you some of my views on this troubling problem.

It is becoming increasingly apparent that a number of young people today are faced with crises in their lives that they feel unable to cope with. Lacking either the knowledge, strength, or resources to help them through these difficult times, they resort to the ultimate form of self-destruction, the taking of their own lives.

The statistics are truly disturbing. Over the last 20 years, the suicide rate of people 15 to 24 years old has more than doubled and suicide now ranks as the third leading cause of death for this age group. Even more distressing is that younger children, 13, 10 even 7 years old are contemplating, attempting, and tragically committing suicide with increasing frequency.

I am deeply concerned that these children and teenagers believe that they have no other option, that suicide is the only solution to their problems. Friends and families of young suicide victims often report receiving few clues or indications that these youngsters were contemplating suicide.

It is essential that we create an environment in which a youth who is depressed, angry or distressed can find the help that he or she needs. We must take steps to educate ourselves as parents, teachers, and peers about the signs of a teenager in trouble and to learn how best we can help him or her through these times of turmoil and despair.

Research indicates that a number of factors may be at work, but the reasons underlying many teen suicides remain a mystery. Experts are only just beginning to sort through the available data in an attempt to understand more fully this rising epidemic.

I believe that some of the testimony presented here today will help shed light on the subject. As a former chairman of the Subcommittee on Child and Human Development in the Senate, I am committed to improving the quality of life for a nation's single greatest resource, our children.

They have special needs, particularly, in their adolescent years that must be addressed. Too often we have ignored the concerns and problems of teenagers hoping perhaps they will outgrow them as they move out of adolescence. In too many cases, the price of this inattention has come in lost lives.

It is time to address realistically the phenomenon of teenage suicide. It is time to find ways in which families and friends join with mental health professionals and with assistance from the local, state and federal government can work together to avert further tragedies.

We must put together a coordinated public health education program which will make available to young people the help they need to work through their difficulties. Over six thousand people under the age of 25 committed suicide last year. That is six thousand lives that will never a chance to realize their full potential.

Together, I believe we can work to reduce that number and help all of our children reach adulthood prepared to take their places as productive members of our society. I thank you again for the opportunity to contribute to this hearing.

Mr. LANTOS. Thank you very much, Ms. Forstner. Please convey my personal thanks to Senator Cranston.

Dr. Smallwood, we will be very happy to hear from you.

STATEMENT OF DR. CATHERINE SMALLWOOD, PH.D., DIRECTOR OF THE CINDY SMALLWOOD FOUNDATION, PROGRAM ON QUASI-MORTICIDE, SAN MATEO, CA

Dr. SMALLWOOD. I will be discussing quasi-morticide, a national crisis in the black community, and I will define quasi-morticide later on.

In the past, suicide was virtually alien to black Americans. Just as the poor committed suicide less frequently than the affluent, blacks committed suicide less frequently than whites.

Today, however, suicide is increasing at an alarming rate among the black population. Suicide per se is not the leading cause of death among black Americans, but rather the third after homicide and accidents. When we see the connection between homicide, suicide, and other subintentional forms of death, than suicide becomes the leading cause of death in the black community.

Quasi-morticide is a grouping of self-deprecating behaviors, subintentional suicides, and other aberrant behavior currently at crisis proportion in the black communities all over the country.

Alcoholism, drug addiction, suicide, homicide, and avoidable accident rates all show the ever rising incidence of quasi-morticide in the black community and its disproportionate share compared to American society as a whole. Recently, there has been a rise in the black male and female suicide rates.

A study carried out in 1976 highlights this growing phenomenon. James A. Bush and his study titled "Similarities and Differences in Precipitating Events Between Black and Anglo Suicide Attempts" depicts the dilemma many black Americans are facing today. Twenty-five black and twenty-five Anglo-American mental health patients who had sought psychotherapy from Dr. Bush were interviewed.

Out of the 25 black male and female samples, 7 had actually attempted to commit suicide, and the remaining 18 had seriously considered and verbalized intentions about possible self-destruction. In the Anglo- American sample, 6 respondents had actually attempted suicide, and the remaining 19 had seriously considered it. This similarity decreases when we view the age category of each group.

In the black group, the age range from 19 to 46, while in the Anglo group it ranged from 21 to 62. The age that blacks consider suicide then becomes an important factor. It has been recognized that the overall suicide pattern between blacks and Anglos is quite different. Generally, according to this study, black suicide attempts come mostly from the youth of the community, while Anglo suicide is found in the older category.

Coupled to this, Dr. Richard H. Seiden in an article titled "Mellowing with Age, Factors Influencing the Non-White Suicide Rate" stated that what had obscured the extent and pattern of nonwhite suicide for many years was the practice of comparing total white and non-white suicide rates rather than using age, specific rates.

Thus, what Dr. Seiden and Dr. Bush have pointed out is the increased suicide occurring among the young in the black community. In mental health and related fields, suicide and homicide have been viewed as two sides of the same coin. A person who commits

suicide can be seen as acting on a more basic homicidal wish turned inward.

To emphasize this point, many perpetrators of homicide graphically end and turn the death weapon upon themselves. This is one of the basic connections in our study of suicide rates. The auto destruction of a black homicide syndrome that is now accelerating in most urban communities is part of the phenomenon which threatens black people's very existence.

When Dr. Morris, a leading black researcher and writer who looked at the broader age category, 15 to 44, he found that the homicide rate is 5 to 10 times higher for black males than it is for his white counterpart. Also as a victim, the black male is more likely to be killed by another black male who is 3 to 4 years younger. Actually, both parties are victims.

Added to this, black females are killed 3 to 4 times more frequently than white females. Coupled to these rising suicide and homicide rates, there is also a rise in what we see as a subintentional forms of death. Subintentional being when an individual plays an indirect covert, partial, or unconscious role in his own demise.

Included in this category is gambling with death, body abuse through drugs, alcohol, and other such actions. Death rates from questionable accidents and violence from 1960 to 1978 show a similar pattern of quasi-morticide.

By way of conceptualizing a new combination of suicide, homicide, and subintended and questionable accidents, we have come to the conclusion of quasi-morticide.

This has serious implications for the black community because not only does this represent a tragedy to the aggrieved families and friends, but also the acute laws of human resources, benefits of earned wages, procreative and nuturing sources, and many other contributions which might have been made to society as a whole.

Only drastic community organization and self-redirection with emphasis on prevention has a chance to halt the rising morticide rates and eventually reverse them. Our program must be preventive with emphasis on environmental change.

In terms of solutions, we are in desperate need of financial backing from the Federal and/or private funding in order to—what we would do, we would utilize these moneys, these funds for would be educating the population which is the priority on the problem of QM. Additional resources or research into causes and solutions to QM, hiring qualified professionals to set up a national committee to explore target QM areas where problems are most concentrated, and hiring a professional staff to set up QM centers and target areas equipped with trained clinicians and counselors and to make available 24 hour hotlines. Thank you.

Mr. LANTOS. Thank you very much, Dr. Smallwood. Finally, I am very pleased to call on Dr. Everell Mitchell who is director of pupil personnel and guidance at the Oakland Public School Systems. Dr. Mitchell.

STATEMENT OF EVERELL MITCHELL, DIRECTOR OF PUPIL PERSONNEL AND GUIDANCE, OAKLAND CA, PUBLIC SCHOOLS

Ms. MITCHELL. It's not doctor, but thank you. I will leave it. My official title is head of psychological services for the Oakland school district. We have a staff of 40 psychologists who provide service to 100 school sites and around 50,000 students. It is a good sized school district.

I will speak to the issue of adolescent suicide and the more general issue of adolescents in crisis from the vantage point of the school. Over the last couple of years, the numbers of students who have been brought to our attention because of suicide attempts have shown a marked increase.

Schools, of course, deal with teenagers for a good part of their day, and problems students have often surface at school. School staffs are constantly being asked by troubled upset, depressed, angry youngsters for some help with their problems or some sense of direction.

Dealing with the mental health problems of students is an area very few staff members are trained in and many are uncomfortable even discussing the problems. So it is difficult to deal with. The problems students have vary widely in scope, even for those who attempt or contemplate suicide.

I think that has been evident from the testimony already. Some are depressed, some are angry. Many that we see in the schools have serious problems with their families. They feel isolated, tend to focus on what they consider to be their defects, and think no one cares about them.

We have noticed lately an increase in abnormal and suicidal behavior in the minority groups in our schools, and that is a relatively new phenomenon for us. The causes of suicide in adolescents in crisis are many. There are lots of roots to the problem, and the increases are apparent in the suicide rates to us.

Schools don't have the answers for how to deal with many of the problems and problem behaviors that students present. Teenagers talk about and attempt suicide in increasing numbers. We need to be prepared as a school system to handle this. We need guidelines on sensitizing staff to student problems. That's critical.

Providing help to students who talk about attempting suicide and dealing with the possible repurcussions. The problem of teenage suicide is widespread and requires national attention. We would support the idea of a national commission to study and make recommendations for Federal action about suicide. Thank you.

Mr. LANTOS. Thank you very much, Ms. Mitchell. Let me just raise the same question that you addressed in the last few moments. Do the other members of the panel feel that the Federal Government should bring together the finest experts in the country in this whole field that we have been talking about all afternoon to provide leadership and guidance, and conceivably matching funding for the various States?

Would you begin, Dr. Drakulich?

Dr. DRAKULICH. I think that you expressed the need very eloquently and I cannot see how we can avoid looking at a very global

picture. The Government and the individual States, all need to play a partnership role and matching funds would be extremely appropriate. I speak as an educator who also did a great deal of teaching and counselling—also as a high school nurse for many years in a very large school district—San Diego unified, to be exact. And the last person giving testimony, really hit the nail on the head so to speak. Something is happening in our society that is changing the direction of the ways that students feel about themselves and their feelings of hopelessness and their feelings of aloneness. And their feelings of despair. I worked extensively in the area of drug and narcotic education and I see a very strong correlation there. And I think that if we are going to approach this problem, we have to look at the whole generic prevention approach and working basically with the families, very closely and working with the students. Somehow the students feel that they cannot handle rejection, that is one of the most difficult things that we all have to look at. They cannot handle the fact that they cannot be successful at all times. Their coping skills need to be developed and enhanced. And I also think that we need to really very closely look at how we can listen more to ourselves as well as to our students and to our children. Just providing open communication does not provide the listening that we really have to experience and work on.

Whether it is in a relationship with a husband and wife, or children or teachers, or counselors, I think that this is the one skill that we lack and that we have to work on very, very much.

So if we can establish a commission that would address some of these very generic prevention approaches, I think that we are getting started in the very right direction, thank you.

Mr. LANTOS. Thank you, very much.

Ms. Forstner, do you care to comment?

Ms. FORSTNER. Thank you, very much.

Briefly, I would like to say that as a member of the Senator's staff, I appreciate your putting this together because I know that we hear about the issue a lot, although most people in Congress are somewhat isolated from the problem and I think that the Senator's statement is pretty clear that the Federal Government finally needs to listen to this and to listen to people on the local level. I do understand what our role can best be in trying to promote an added awareness on both the local and State governments, and it is helpful working on the Federal level to hear the testimony and to understand what those problems are.

And I certainly will be looking forward to working with you on that.

Mr. LANTOS. And we look forward to that.

Dr. Smallwood, what is your view of a Federal Commission on this issue?

Dr. SMALLWOOD. As I had indicated in my presentation a Federal Commission is one of the necessities that will allow the implementation of our program.

In addition, I have been in contact with Dr. Mitchell who gave me a working copy of bill H.R. 5931. Consequently, our QM Committee reviewed it, and returned it with strong recommendations. Of course we are in agreement.

Upon completion of final volume, please forward a copy of Congressional Record and any other publication in which remarks appear.

Mr. LANTOS. I appreciate it. And Ms. Mitchell you have already expressed your view on this.

Before I thank this outstanding panel and all of our witnesses, let me say that I have attended and participated in and listened to countless hearings in the Congress both in the House and in the Senate, and this was one of the most extraordinary, thoughtful, serious, and substantive set of presentations. I will take all of this information back to the committee and we shall move forward on this legislation.

Two individuals who were invited to participate in this hearing today were not able to be present with us. They have prepared written testimony which will be included in the record at this point.

First is a statement of Susan J. Blumenthal. M.D., Head of the Suicide Research Unit of the National Institute of Mental Health of the Department of Health and Human Services.

[The prepared statement of Ms. Blumenthal follows:]

PREPARED STATEMENT OF SUSAN J. BLUMENTHAL, M.D., HEAD, SUICIDE RESEARCH UNIT, CENTER FOR STUDIES OF AFFECTIVE DISORDERS, CLINICAL RESEARCH BRANCH, DERP, NATIONAL INSTITUTE OF MENTAL HEALTH

Thank you for the opportunity to submit a statement for the record on behalf of the National Institute of Mental Health (NIMH) on the subject of suicide. I am pleased that the Subcommittee is concerned about this major public health problem in our country and would like to commend your leadership role in examining this area of national concern.

I am Dr. Susan Blumenthal, a board certified psychiatrist, and I am Head of the Suicide Research Unit in the Center for Studies of Affective Disorders at the National Institute of Mental Health. The Suicide Research Unit coordinates NIMH's program in suicide research, conducting research projects, conferences, and workshops, and prepares scientific presentations about suicide to professional groups and to the public. In my psychiatric training and practice, I have had considerable clinical experience with the treatment of suicidal individuals.

My statement includes information on the scope of the problem of adolescent suicide in the United States, and reviews our knowledge based on research findings on the psychosocial, psychiatric, familial, genetic and biological aspects of suicide, focusing on adolescent suicide.

SCOPE OF THE PROBLEM

Suicide is a major and devastating public health problem. According to the most recent figures collected by the National Center for Health Statistics, suicide is the tenth leading cause of death in adults. A conservative estimate is that there are 200,000 suicide attempts and 30,000 completed suicides in the United States each year. As of 1980, at least 1,000 suicides occurred every day in the world and over 600,000 years of productive life are lost each year in this country. This number is assumed to be a minimal estimate since suicide is heavily underreported because of its social stigma. For example, many single motor car accidents and homicides may, in fact, be suicides.

Those individuals at highest risk for suicide are white males with highest rates being among men ages 25–34 and beyond age 41. Men commit suicide four times as frequently as women. Suicide rates for whites are twice as frequent as for non-whites. As compared to whites, non-whites show a much sharper peak in suicide rates in the 25–34 age group and decline and leveling off in older age groups. Suicide is more common in single, divorced and widowed individuals. The rates for married men and women of all ages is consistently lower. Suicide rates are high among unemployed persons.

Suicide in the elderly

A gradual rise in the overall suicide rate occurs with increasing age. The suicide rate in the 85 years and older age group is nearly twice that of the national average. Stratification by sex and race in this age group reveals that the risk is highest among older white men. In fact, they account for nearly one-third of all suicides, although they make up only 10 percent of the total population. Unless there are significant changes, increasing rates of suicide are predicted for older Americans in the 1980's and 1990's.

Among the elderly, unrecognized and untreated affective disorders, the presence of a physical illness, the stresses of aging, bereavement and isolation are the most powerful predictors of suicide.

Bereavement substantially heightens suicide risk. In the first year after the death of a spouse, the relative risk of suicide is 2.5 times greater than in the general population. In the second year, it is 1.5 times greater than that of the general population. Bereavement of course is especially prevalent in this age group.

Physicians see 50 percent of the elderly people within a week prior to their suicide, and see 90 percent in the three months prior to the suicide.

The presence of an clinical depression is a highly associated risk factor for suicide among the elderly, but many physicians who are unaware of the signs, symptoms and treatments of depression will diagnose dementia in older people rather than detecting the depression which can be treated.

Adolescent suicide

Over the past 30 years, the United States suicide rate for people 15 to 24 years of age has increased dramatically from 4.1 per 100,000 in the mid-1950's to 12.5 per 100,000 in 1980. As a consequence, suicide moved from the fifth leading cause of death in this age group in 1960 to the third leading cause in 1981. Research data also indicate that suicide is the second leading cause of death among college students. Between 1970 and 1978, 39,011 United States residents 15 to 24 years of age committed suicide. During this same period, the suicide rate for this age group increased 41 percent while the rate for the rest of the population remained stable.

This increase in reported suicides for young people is due primarily to an increasing number of suicides among white males; rates for males increased by 47.4 percent compared with an 11.9 percent for females so that by 1978, the ratio of suicides committed by males to those by females was greater than 4 to 1. At the same time, however, it should be recognized that young women attempt suicide 4 to 8 times more frequently than males.

Recent data from the Centers for Disease Control [CDC] show a rise in suicide among young black males. Unfortunately all other minority groups are clustered into the category "other". In response to this lack of data, the CDC and NIMH are collaborating on collection and analysis of more detailed information on this in five Southwestern states.

Adolescents are not only more likely to attempt suicide, they are also more likely to use lethal methods in those attempts. From 1970 to 1978, the proportion of suicides committed by firearms or explosives increased for both males and females, while the proportion of both males and females committing suicide by poisoning declined. These changes were more marked among young women, who have traditionally committed suicide by poisoning.

Suicidal behavior occurs in younger children. A recent study by Dr. Pfefer at Cornell Medical School has shown that 13 percent of the 6 to 12-years olds randomly selected from Westchester County elementary and junior high schools had suicidal thoughts, and 3 percent had made suicide attempts that had not previously come to anyone else's attention.

Another characteristic of the current suicide problem merits serious concern. "Suicide clusters" are occurring at an increasing rate among adolescents. The term, "suicide cluster," refers to the phenomenon of one suicide appearing to trigger several other suicides in a group, such as a school or community. Very little is known about this apparent contagion effect of suicide among adolescents. Suicide clusters have recently occurred in Plano, Texas, in Westchester County, New York, and in Clearlake and Houston, Texas.

The trend of increasing rates of suicide among adolescents and young adults has been unremitting since 1950. There is no reason to believe that this will change in the foreseeable future until we improve our understanding of why suicide occurs and learn to prevent this tragic public health problem.

RISK FACTORS FOR SUICIDE IN ADOLESCENTS AND YOUNG ADULTS

There are many reasons why young people commit suicide. The factors involved are complex, highly interrelated, and only partially understood. The causes are psychological, biological, and sociocultural. Many current prevention strategies are based on clinical experience, not on empirical research.

Psychiatric risk factors

The persistence and clustering of symptoms that may indicate the presence of depression—changes in sleep and appetite, weight loss or gain, restlessness, fatigue, loss of interest in usual activities, feelings of hopelessness or guilt, sudden need or behavior changes, withdrawal from friends and family, and decreased concentration—are important warning signs of possible suicidal behavior in young people. While not all young people who attempt or commit suicide have a diagnosed psychiatric disorder, depression, either diagnosed or unrecognized, is the most important risk factor for suicide. 15 percent of depressed individuals die by suicide. For all people suffering from schizophrenia, 15 percent will die by suicide.

Complicating and sometimes precipitating suicidal behavior in young people is the abuse of alcohol and drugs. It is known, for example, that adolescents account for 15–16 percent of drug-related suicide attempts seen in hospital emergency rooms. Alcohol, drug abuse and chemical dependency appear to be significantly linked to suicide attempts and completions. The "Fifth Special Report to the U.S. Congress on Alcohol and Health (1983)" notes that as many as 80 percent of those who attempt suicide have been drinking at the time. Moreover, it is estimated that alcoholics commit suicide from 6 to 15 times more frequently than the general population. Other psychiatric risk factors for suicide include a previous suicide attempt and communication of suicide intent. Therefore, one of our most important prevention strategies is the early detection and treatment of mental disorders and chemical dependence in young people.

Psychosocial risk factors

There have been few studies that systematically investigate psychosocial risk factors for adolescent suicide. Research studies sponsored by the NIMH are under way to develop high-risk profiles for young people. What we currently know is that adolescents who attempt or complete suicide (two distinct but overlapping phenomena characterized by different risk factors) are feeling alone, hopeless, and rejected. For some, these feelings accompany running away from home, and unwanted pregnancy, being the victim of child abuse, having experienced a recent humiliation in front of family or friends, having parents with alcohol, drug abuse or chemical dependence problems, having a family history of suicide or affective disorders, or having a family life in which there is parental discord, disruption, and separation and divorce.

Adolescent suicide attempters are predominantly girls with the following characteristics: a history of psychiatric illness, suicide attempts, high stress, broken homes characterized by divorce and parental discord, and a history of psychiatric illness and suicidal behavior in the family. The few studies of personality findings in this group reveal isolated, angry adolescents, some of whom have a history of impulsive behavior and substance abuse.

The scarce literature on adolescent suicide completers reveals that they are predominantly boys, many of whom have experienced a disciplinary crisis leading to humiliation, and have a family history of suicidal behavior. An associated chronic illness has been found in some young people who commit suicide as well as a history of a psychiatric illness. Family disruption seems to be less of a factor in this group. Personality characteristics of adolescents who complete suicide have included antisocial behavior and/or a history of aggressive and implusive behavior.

Biological risk factors

Recent biochemical investigations of suicidal behavior have shown that suicide victims and suicide attempters have a deficiency in a key chemical messenger in the brain, a neurotransmitter called serotonin, which is associated with the regulation of aggression, mood and memory in the brain. Furthermore, reduced central serotonergic activity is associated with suicidal behavior, not only where there is a diagnosis of Major Depressive Disorder, but also in association with a range of other psychiatric disorders. This research has also found a common biochemical association between agression and reduced serotonergic function. Some studies suggest tht the finding of decreased serotonin and violent suicide attempts may increase the risk of completed suicide twenty-fold at one year followup. Other work on neuroendocrine findings in suicidal behavior is under way. Research on biological factors may hold

promise for increased prediction of suicide, new psychopharmacologic treatment interventions, and ultimately prevention of suicide.

Genetic and family risk factors

A family history of suicide is a significant risk factor for suicide. Explanations for this include the psychological phenomenon of identification with a family member who has committed suicide, genetic factors for suicide, and the genetic transmission of psychiatric disorders. A sutdy of psychiatric inpatients revealed that (1) half of the persons with a family history of suicide had attemped suicide themselves, and (2) over half of all patients with a family history of suicide had a primary diagnosis of affective disorder. Other studies have suggested a high concordance rate in identical twins for suicide. Research has also shown that biological relatives have a six times greater increase in suicide than adoptive relatives.

A study of the Amish, a group of religious people who have a 300-year history of non-violence, no alcohol or drug abuse, a high degree of social cohesion, no divorce or family dissolution, and where the ultimate sinful act is to take one's own life, has revealed an enexpected finding—suicides do occur among this group. There have been 26 suicides in this group clustered in several families in southeastern Pennsylvania over a 100-year period (1880–1980), with a seasonal pattern (peaks in March–May, September–November). Twenty-four of the 26 suicides could have been diagnosed as major affective disorder.

The research discussed in this section suggests possible family history and genetic factors in both affective disorders and suicide.

UNANSWERED QUESTIONS ABOUT ADOLESCENT AND YOUNG ADULT SUICIDE—RESEARCH NEEDS

The variation in suicide-death rates in different age, sex, and ethnic population groups suggests the existence of both high-risk and protective factors. Ongoing studies sponsored by the NIMH will offer new information on biological and behavioral risk factors for suicide. More basic and clinical research on suicide and affective disorders is needed before we can infer the nature of these factors. Since only two studies, both of them very limited in scope, have been focused exclusively on children and adolescents, much more research on this age group is essential to form the basis for rational treatment and prevention. Questions that need to be answered include:

Risk factors

The prevalence of clinical diagnoses among adolescents who attempt and commit suicide, in particular, the proportion of affective disorder, of psychotic or antisocial disorder.

The prevalence of the association of suicide and suicide attempts with alcohol, drug abuse and chemical dependence.

The prevalence of the association of suicide and suicide attempts with predisposing or precipitating factors such as disturbed school or family life, acute stress such as physical illness, pregancy, and arrest. How do the groups differ with respect to these factors from each other and normal controls?

The prevalence of a family history of suicide, depression, alcohol use, or other abnormal personality characteristics. Does a family history of these factors act through genetic or environmental mechanisms or as an interaction of both?

The extent to which suicide occurs in adolsecents who already received psychiatric treatment.

The extent to which having a family member or friend attempt or complete suicide contributes to suicidal behavior in adolescents.

The extent to which suicidal behavior in adolescents is associated with news media coverage of the suicide problem or with the public reporting of sucidal deaths. What is the mechanism for "cluster suicides"?

The extent to which isolation for the adolescent from his/her peer group contributes to suicide completions and suicide attempts, comparing this with nonpsychiatric control groups.

Biological risk factors and possible biological markers for suicide and affective disorders in adolescence.

Prevention

Determination of the effects of high school suicide prevention education programs on young people. The development of evaluation components for these programs is essential.

Determination of what educational methods, services, and treatment strategies are effective in preventing adolescent suicide.

Development of more effective service programs with evaluation components.
Development of valid diagnostic instruments for assessing suicidal intent and risk.

NATIONAL INSTITUTE OF MENTAL HEALTH'S RESPONSE TO THE NATION'S SUICIDE PROBLEMS

In recognition of the seriousness of the problem of high suicide rates among young people, the NIMH has begun to increase its focus on research efforts on this issue. Among them are:

Establishment of suicide research unit

In Fiscal Year 1983, NIMH established a Suicide Research Unit (SRU) within the Center for Studies of Affective Disorders to develop a knowledge base and to support research related to suicide. Through its research support, NIMH hopes to reduce the suicide rate in high-risk populations through research on improved diagnosis and treatment of psychiatric disorders. The SRU stimulates new research in the area of suicide; collects and disseminates information about suicide to the public, professionals, and the media; and coordinates suicide research-related activities within the NIMH.

Extramural Research Program

There has been a substantial increase in the number of funded grant applications on suicide. The NIMH currently sponsors eight research projects with aspects on adolescent suicide in its extramural program at a total cost of $644,343. A Request for Applications on Suicide is planned for FY 85. In particular, research on suicide preventive interventions will be targeted.

Intramural Research Program

Intramural research at the NIMH includes studies on possible biological markers for suicide, the relationship of biochemical factors, aggression and suicide, familial factors in suicide, alcohol abuse and suicide, and research on affective disorders.

Publications and Information Dissemination

A series of publications and informational materials on suicide for the public and scientific community are being prepared.

Suicide Monograph—A new monograph for the public on suicide is planned for distribution in spring 1985.

Videodisc on Adolescent Suicide—A videodisc on the assessment of adolescent suicidal behavior for medical student and resident training is planned for distribution in the summer 1985.

Black Suicide Monograph—A monograph on Black suicide will be distributed in spring 1985.

Information Dissemination—The NIMH continues to work actively with the media to promote public education about suicide and responds to numerous public and professional inquires on suicide.

Project Depression

Currently, the major suicide prevention strategy is the early detection and treatment of affective disorders since the presence of an affective disorder is the most common precursor of suicide (60–80 percent of those individuals who have completed suicides suffered from an affective disorder). Recent reports described by Drs. Jamison and Akiskal following 9,000 affective disorder patients for 9 years in three major affective disorder clinics in university medical centers suggest that intense treatment of affective disorders yielded a decreased suicide rate in this population. Specifically, there have been only five suicides for this group, whereas base rates would have predicted 50 suicides. Since adolescent depression is not well recognized or detected by either parents or physicians, improving the diagnosis and treatment of depression in young people by health care providers is expected to decrease their suicide rate. To achieve this goal, the NIMH is planning a major public and professional education campaign on depression. This campaign, entitled "Project Depression" is designed to increase the recognition, early detection, diagnosis, and treatment of affective disorders.

Suicide prevention activities

The NIMH is approaching prevention of suicide in a number of ways:

Currently the most effective strategy for prevention of suicide is the early detection and appropriate treatment of depression, substance abuse, and other psychiatric disorders. In order to foster earlier detection and more effective treatment, more comprehensive education is needed for individuals at high suicidal risk, their fami-

lies and loved ones, primary care physicians, and other health care providers and mental health specialists. The Alcohol, Drug Abuse & Mental Health Administration is planning a special initiative to improve primary care physician awareness of alcohol and drug abuse, chemical dependency, and mental health disorders.

Specialized educational programs are being tried in many locations. Recently, State legislatures in California and Florida have mandated the teaching of suicide prevention education in high school curricula. There is, as yet, no research available evaluating the type and effects of such curricula on young people. The NIMH is planning to stimulate research in this area.

The preventive effectiveness of suicide hotlines and crisis centers has yet to be systematically shown. Yet, this lack of evidence should not be interpreted to mean that hotlines and centers are ineffective. It is unclear that people who contact suicide hotlines are those individuals at highest risk for completing suicide. The NIMH is encouraging research to clarify what populations utilize these services, what services are offered, and to evaluate the effectiveness of intervention offered.

The SRU plans to commission a review of the suicide prevention literature to assess current knowledge about the effectiveness of suicide education programs, hotlines, and suicide crisis centers. Based on this review, recommendations for evaluation of educational and service programs and prevention strategies will be developed.

Conference and Workshops

NIMH sponsored a workshop on "Prevention Research: Suicide and Affective Disorders Among Adolescents and Young Adults," December 1982, which explored future directions of research on adolescent suicide.

A workshop on the "Contagion Effect in Adolescent Suicide" is planned for the January of 1985. Participants at this workshop will explore possible mechanisms for the cluster effect in adolescent suicide, examine recent contagions in Westchester County, New York, Plano and Houston, Texas, and will discuss prevention strategies.

State-of-the-Art Conference on Suicide—A major 3-day conference on "The Psychobiology of Suicidal Behavior" to be cosponsored with the New York Academy of Sciences is planned for September 1985. Research on behavioral and biological risk factors for suicide will be presented and future lines of research will be discussed.

Collaboration with other Federal agencies

The NIMH collaborates with other Federal agencies to improve surveillance mechanisms and the data base for suicide information in this country.

NIMH-CDC Collaboration—The NIMH and the Center for Disease Control (CDC) are collaborating on a number of research projects. Current projects include: (1) adolescent suicide; (2) Hispanic suicide; and (3) the relationship of marital status and suicide.

Suicide Research Unit Advisory Group—Establishment of a group of national experts in suicide and affective disorders is planned for FY 85 to consult with the Suicide Research Unit, review the current NIMH grant portfolio on suicide, identify gaps, and recommend further areas for research.

CONCLUSION

The trend of increasing rates of suicide among adolescents and young adults has been unremitting since 1950. We have no reason to believe this will abate in the future without substantial improvement in our understanding of the causes of suicide.

This improvement can be achieved only through careful scientific inquiry and evaluation. We must strengthen our knowledge about psychiatric, psychosocial, biological, and genetic risk factors for suicide. At present the research evidence points to early detection and effective treatment of depression, alcoholism, drug abuse, and other disorders as the best chance to reduce the suicide rate in young people.

Thank you for the opportunity to submit this report on the subject of suicide. The National Institute of Mental Health would be pleased to provide the Subcommittee with any further information you should require.

Mr. LANTOS. Second is a statement of Kim Smith, Ph.D., diplomate in clinical psychology of the Menninger Foundation of Topeka, KS.

[The prepared statement of Ms. Smith follows:]

PREPARED STATEMENT OF KIM SMITH, PH.D., DIPLOMATE IN CLINICAL PSYCHOLOGY, THE MENNINGER FOUNDATION, TOPEKA, KS

I offer this brief report on youth suicide from the perspective of an experienced psychotherapist and suicide researcher. I am deeply concerned that the suicide rate for white males in the 15–24 year age range for the year 1980 had never been higher in American morbidity statistics (according to recently published data from the Natonal Center of Health Statistics). The rate for young black men has also shown a similar staggering increase. Furthermore, my own recent research underscores the findings in the literature which show that between 8.4 and 13 percent of "normal" high school students have made at least one suicide attempt. When such figures are extrapolated to all 15–19 year-old youth, then between 1.6 and 2.4 million adolescents are likely to have made one or more suicide attempts. To be sure, most of these attempts are of a mild or nonlethal nature (Smith and Crawford, 1984). Nevertheless, it is clear that our youth, and in particular our young males, are having an increasingly difficult time growing up in our society. There are a number of likely societally-based causes for this suicide impetus. One of the facts about which we are fairly sure is the compelling research evidence supporting the relationship between increases in the suicide *rate* and periods of increasing birth density. Because the birth rate in the mid to late seventies was significantly lower than the birth rate in the 50's and 60's, we can anticipate that the youth suicide rate will begin to level off in the mid-1980's and even begin to decrease during the 1990's. However, it is a rather calloused society that does not attempt to minimize this terrible drain on our precious national resources. My research, as well as that of other colleagues, continues to show that those who make very serious efforts to end their lives are often among the brightest and most achievement oriented youth in our society. The loss of these people not only affect our country psychologically and morally but likely also in economic ways as well.

Up to this point, our major preventive measure has been the Suicide Prevention and Crisis Centers. Recent studies have shown that the suicide crisis and prevention centers are probably most effective in working with female attempters. As you know, the suicide rate for 15–24 year-old females has not varied significantly since 1940. However, males are not as prone to call hotlines. We need, therefore, other mechanisms to reach this most high risk group. I would like to offer three suggestions for additional programs:

1. Develop a curriculum on suicide and crisis management for the schools. The point of this curriculum would be to help students understand that feeling suicidal is relatively common to the human condition. Such feelings are a sign that important ways in which the person is approaching life need to be modified; they are not a "call to action." Students need to be taught how to better cope with their own crises as well as those of their friends. It is very important to help students know how not to become overly involved with another suicidal friend but to have the courage to pass the problem on to helpful adults. As we all know teenagers tend to feel strongly about issues. The problem is that they often feel strongly one way one minute and strongly the other way the next. To the adult we understand this as "ambivalence" but the concept of ambivalence or having mixed feelings about the same thing is new to the teenager. The importance of teaching teenagers about ambivalence is that suicidal feelings are almost always strongly ambivalent feelings. Once the person initiates the suicidal act, they are often caught up by the other side of their feelings: their fear of dying. Finally students need to be taught about the nature of depression and how it helps one to focus on one's worst attributes while diminishing in importance th good things, both in themselves and in others. Such concepts provide the student with ways to think about their suicidal feelings and as such serve as buffers to direct action.

2. Regional or statewide "suicide awareness and resource centers" could be developed. The purposes of these centers would be to identify treatment, preventive and postventive resources within the region; to coordinate intervention and prevention efforts; to provide accurate and current information about suicide; and, to insure the proper and smooth running of suicide "response teams".

3. The formation of "suicide response teams" could be mandated. These would be groups of professionals within local communities who would have an agreement with local school systems that once a suicide does occur the team would be mobilized to provide information and reduce worry and tension among those involved. This will probably be the single most effective means to combat the "contagen" effect produced by an actual suicide. These teams would be trained to meet with worried parents, distraught students, shaken teachers and anxious administrators. The particular workings of such a team are very complex and if done poorly could

actually exacerbate the problem. A curriculum for training these teams and guidelines for their work need to be devleoped. The concept of the suicide response team promises to be a major new tool for reducing the degree of destruction following a suicide and for helping a community begin a healing process.

Mr. LANTOS. There is one observation that I cannot help but make, and I am making it really as an academic observation because there are probably no two members of the Congress who are more concerned with the issue of nuclear weapons proliferation than Senator Cranston and I, and the importance of beginning to move towards verifiable and balanced arms reductions.

But I find it remarkable, although personally not surprising, that not one of our dozen witnesses even tangentially touched upon the global issues that are contributing as a factor to this issue. All of the items that have been listed by members of families of victims and professionals—whether individuals running centers like Ms. Ross, or people in the field of psychiatry or psychology, or school counselors or the State department of education—basically have all dealt with the perennial issues of the family, problems with members of the opposite sex, pressures in school, alcohol, and drugs. But the cosmic issue which the popular press so often deals with as the cause for juvenile despair, or middle age despair, or elderly despair, mainly, that we are living at the brink of a nuclear abyss at no time was mentioned during the course of these hearings. I find this both interesting—but as I say, not surprising—because I have often felt as a layman interested in this issue, that people act in these manners on the basis of very personal considerations—of failing at school, of not being able to communicate with family or having lost somebody very close—but not in terms of the global issues that summit conferences are all about.

I do not know if any of you care to agree or disagree or just let it go. Let me express the appreciation of the committee for your testimony and your time in this hearing.

This hearing is concluded.

[Whereupon the hearing was adjourned at 5:03 p.m.]

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